DOCUMENT RESUME

ED 222 589 UD 022 535

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TITLE A New Conceptual Framework for Mental Health Clinical Service Research on Hispanic Populations.
INSTITUTION Fordham Univ., Bronx, N.Y. Hispanic Research Center.
SPONS AGENCY National Inst. of Mental Health (DHEW), Rockville, Md.
PUB DATE 82
GRANT 1-R01-MH-30569-03
NOTE 29p.; Funded by the Minority Group Center.
AVAILABLE FROM Hispanic Research Center, Fordham University, Bronx, NY 10458 (write for price).
JOURNAL CIT Research Bulletin; v4,5 n4,1 Oct-Jan 1981-1982 v5 n2-3 Apr-Jul 1982

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Clinical Diagnosis; Cultural Influences; *Hispanic Americans; Language Role; Literature Reviews; Measurement Techniques; *Mental Health; *Mental Health Clinics; Mental Health Programs; Models; *Psychiatric Services; Psychological Evaluation; Psychotherapy; Rehabilitation; *Research; *Research Needs; Social Influences
IDENTIFIERS *Hispanic Research Center NY

ABSTRACT

This report examines selected studies on the search for and utilization of mental health facilities among Hispanic populations and presents a framework for research on mental health services for Hispanics. Shortcomings of available data on this topic are reviewed. The research framework proposed is based on the assumption that clinical service research spans a hypothetical time sequence, beginning when a person experiences mental distress and ending when the person resumes his or her customary social role after undergoing therapy. An explanation of modifications in the present model is followed by discussion of five phases of research: (1) psychiatric epidemiology, (2) utilization of mental health facilities, (3) psychiatric assessment, (4) therapeutic modalities, and (5) post-treatment rehabilitation. Studies planned by the Hispanic Research Center (Fordham University, New York) are described as examples of research in these areas. (Author/MJL)

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ED222589

RESEARCH BULLETIN
HISPANIC RESEARCH CENTER
FORDHAM UNIVERSITY
BRONX, NEW YORK 10458

OCTOBER 1981 — JANUARY 1982 VOL. 4-NO. 4 & VOL. 5-NO. 1

A New Conceptual Framework for Mental Health Clinical Service Research on Hispanic Populations

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UD 022 535

FROM ITS INCEPTION one purpose of the **Research Bulletin** has been to review the literature in topical areas relevant to Hispanic concerns in an effort to raise critically important questions of research and policy. Thus, one issue of the **Research Bulletin**[1] presented an organized review of the literature on the criminal justice system and on how this system enmeshes and influences the lives of Hispanics. In an effort to offset the tendency in some of the professional literature to stereotype the variety of Hispanic subgroups into one homogeneous category, we brought together an array of data documenting Hispanic diversity in New York City.[2] A subsequent issue of the **Research Bulletin**[3] reported additional data on Hispanic diversity elsewhere in the United States. Many of our readers, responding to these issues of the bulletin, found the articles to be informative and of value in charting important paths for research and public policy affecting Hispanics. This issue of the bulletin attempts a similar goal in relation to another important topical area: clinical service research on the mental health of Hispanics. The reason why we believe that this area should be highlighted is because clinical service research with Hispanics, particularly studies that focus on Hispanic patterns of utilization of mental health facilities, has been frequently characterized by shifting issues and theories. Research in these areas often tends to move from one topical area to another as if it had thoroughly posed and mastered the significant questions and provided the reliable data. We want to call attention to the fact that there are basic problems still to be resolved in the area of Hispanic utilization of mental health facilities; therefore, it is an area still in need of competent research attention, innovative formulations, and research-based recommendations relevant to mental health policy.

The literature on clinical service research on the mental health of Hispanics – although sparse in general – is more available for Puerto Ricans and Mexican Americans than it is for other Hispanic groups such as Cubans and Dominicans. Therefore, the review of the literature presented here focuses mainly on Puerto Ricans and Mexican Americans. Our review of this literature, however, is not comprehensive. Our able colleagues on the West Coast, under the leadership of Dr. Amado Padilla, have conducted extensive reviews of the literature on this topic.[4] Our own purpose, instead, is to organize selected portions of the literature according to a conceptual framework encompassing clinical service research. The need for a comprehensive framework is evident in the data presented by the **Report to the President's Commission on Mental Health** (1978). The report notes that there are over 2000 published works on the mental health of the Hispanic population, with over 75 percent published since 1970. However, the report laments the fact that "quality has not kept pace with quantity and the research literature on Hispanic mental health has yet to attain the status of an integrated body of scientific knowledge. It remains plagued by stereotypic interpretations, weak methodological and data-analytic techniques, lack of replicability of findings and the absence of programmatic research."[5] Because Hispanics represent the most rapidly growing minority group in the United States, there is a pressing need to improve the quality of such research. Already the second largest minority group, Hispanics may outnumber the black population in the next quarter century. This rapid growth must be viewed in the context of substantial diversity in national origin, demographic profile, migration status, and settlement patterns.[6] In sum, flawed research, lacking integration, has addressed the important issue of mental health among Hispanics, a rapidly growing and diverse population.

The presentation of a conceptual framework for clinical service research, we believe, will serve a variety of purposes, all having to do with the widely recognized and above-noted need of integrating the literature. The framework will enable us to locate the goals and findings of specific research projects in a broader conceptual structure; to examine the interrelationship of research findings; to identify important gaps in the research, unaddressed by the literature; and to examine and then formulate critically important problems located within the framework. We view our effort as tentative and exploratory, but characterized by innovativeness.

A Sequential Framework for Mental Health Clinical Service Research

In broad terms, we conceptualize clinical service research as spanning a hypothetical temporal sequence. The sequence begins when a person experiences mental or emotional distress, or displays a pattern of dysfunctional behavior, which is viewed by the person or others as a problem requiring help. The sequence ends after official medical or mental health providers have attempted to deal with the problem and the person resumes his or her customary social roles. From the beginning to the end, the sequence can be divided into four phases which sometimes overlap: the first phase involves intricate help-seeking efforts which may lead the person to contact official mental health service providers; the second phase involves attempts -- valid or invalid -- by such help providers to evaluate or diagnose the client's psychological condition; the third phase involves the attempts by help providers to treat the client's emotional distress, successfully or unsuccessfully; and, finally the fourth phase involves the termination of treatment and the client's resumption of customary social roles, relieved of the original problem or not. Clinical service research is any research which focuses upon at least one of these four phases. The research can be descriptively oriented to profile aspects of the phases, or analytically oriented to explain dimensions of the phases. Included, too, are innovative efforts to create and test the efficacy of diagnostic procedures and treatment modalities.

The application of this definition to specific cases of persons experiencing psychological problems would undoubtedly show a variety of patterns or trajectories across the four phases: the duration of the entire sequence could be short or long; some persons experiencing psychological distress may never reach the official help providers, but remain in the population at large, identifiable only by means of true prevalence epidemiological research; others may move through all four phases and, with the original problem resolved, resume their customary social roles; some persons may move through the four phases without relieving or eliminating the original problem which stimulated the help-seeking effort; some persons may not pass through all phases of the sequence; or some may move back and forth through the different phases. Clearly, there are many other possibilities. Thus, when projected against the framework, specific instances of help-seeking efforts will show considerable variety. However, the application of the sequential framework enables research-relevant distinctions to be made in charting the history of attempts to cope with psychological problems.

The sequential framework invites the use of a temporal perspective in examining assumptions commonly held by mental health practitioners and researchers. For example, it is commonly believed that success in either phases two, three, or four presupposes success in the preceding phase(s). For the psychological problem to be diagnosed correctly, the client must first come into contact with a help giver who can conduct the appropriate diagnostic procedure. Moreover, appropriate treatment presupposes a correct diagnosis. Finally the client's successful resumption of customary social roles depends not only upon the efficacy of the treatment received, but also upon a combination of factors associated with the person's life circumstances. We present these assumptions in their simplest terms, realizing fully that the actual clinical service sequence is substantially more complicated. Nonetheless, we believe there is value in the use of such over-simplifications in providing an overview of the clinical service research literature focusing upon Hispanics. The literature emphatically makes the point that Hispanics experience pronounced difficulties in each of the four phases: they underutilize mental health services in relation to their mental health needs; they are prone to be misdiagnosed because of culturally insensitive diagnostic procedures; the treatment they receive does not fit their culture and life circumstances; and, finally, they experience difficulty in resuming their customary social roles after undergoing treatment. The phases comprise successive barriers -- as if they were an obstacle course -- which keep Hispanics from receiving the mental health care they need. This issue of the **Research Bulletin** discusses the first phase -- the help-seeking effort leading to contact with official mental health providers. Subsequent issues of the bulletin will address the remaining three phases.

Hispanic Utilization of Mental Health Facilities

Hispanic utilization of mental health facilities is the central problem of research in the framework's first phase. Admission rates, taken as evidence of utilization of mental health facilities, are based upon the proportion of users of a particular mental health facility, or a number of such facilities, who are members of a Hispanic group in relation to that group's proportionate size in the population or the relevant catchment area. When the first proportion is smaller than the second proportion, the group is said to "underutilize"; when the first proportion is larger than the second, it is said to "overutilize." Admission rates have also been used to make intergroup (ethnic or racial) comparisons in determining over- and underutilization. Research findings based upon either procedure generally point to the Hispanics' underutilization of mental health facilities, although there are, as we shall see, important exceptions to the pattern.

The first part of this report examines selected studies on utilization in the context of Hispanic mental health needs. There are two theories which profer explanations of the Hispanics' underutilization of mental health facilities: alternative resource theory and barrier theory. The theory of alternative resources explains underutilization in terms of the indigenous Hispanic social organizations serving as therapeutic alternatives to the official mental health agency system. The explicit argument is that Hispanics with psychological problems first turn to proximate and culturally familiar indigenous organizations and, if no satisfactory solution of the problem is attained, then, as a last resort, they turn to mental health facilities. The theory of barriers, on the other hand, explains underutilization as a result of structural impediments to professional mental health care. The class of variables or factors each theory utilizes for explanatory purposes also differs, as we shall see in the second part of this presentation. However, although the two theories differ in these respects, they can be integrated into a more comprehensive and dynamic

explanation of Hispanic underutilization. The third part of this presentation attempts this integration in the context of recommendations critically relevant to the framework's first phase.

Research in psychiatric epidemiology, seeking to determine the true prevalence and incidence rates of mental health problems, has a double relevance to our effort to understand Hispanic underutilization of mental health facilities. First, by iden ifying variations in the mental health status of persons across demographic categories and sociocultural groups, such research provides clues relevant to the etiology of mental distress. Thus, much of the rapidly increasing research on the interconnections between stress, changing life events, supportive networks, and mental health is rooted historically in the findings that disadvantaged, marginated groups experience disproportionate mental distress. (The concept of stress, in all of its rich socio-psychological meaning, is postulated to mediate between the overarching structure of society and the specific life circumstances of persons. Elsewhere[7] we have used this body of literature to develop a series of theoretical ideas linking the Hispanics' experience of migration-induced life stresses to psychological impairment and patterns of mental health utilization.) Such research is oriented toward uncovering factors relevant to the sociocultural and psychological origins of mental health distress. Second, psychiatric epidemiology provides empirically based measures of variations in the need for mental health care across demographic categories and sociocultural groups. Findings relevant to etiology and those describing rates of mental health problems, as we shall see, have been of importance in assaying mental health needs of Hispanics.

Arguments for increased mental health care for Hispanics are based partly upon psychiatric epidemiology research indicating that populations with the demographic, socioeconomic, and experiential characteristics of Hispanics present comparatively higher rates of mental illness. Empirical relationships relevant to etiology – whether only hypothesized or confirmed by research – are generalized to subsume the situation of Hispanics. Thus the classic study by Hollingshead and Redlich[8], confirming an inverse relationship between socioeconomic status and treated mental illness, is relevant to the situation of Hispanics: their low socioeconomic characteristics, particularly of subgroups such as Mexican Americans and Puerto Ricans, render them vulnerable to mental health problems. The confirmation of the Hollingshead and Redlich hypothesis, replicated in a variety of settings and in reference to the relationship between schizophrenia and socioeconomic factors,[9] strengthens the application of the inference to Hispanics.

Similarly, there is a long history of research on the relationship between migration and mental health, most of it based upon hospital admission or treatment records.[10] This research exhibits widely recognized methodological problems associated with the study of self-selected institutionalized populations: the inability to introduce appropriate controls in comparisons between "migrants" and "non-migrants";[11] the operational specification of the concepts of migrant or migration;[12] the analysis of undifferentiated categories of "all mental disorders";[13] and the global categories (schizophrenia) subject to unknown margins of diagnostic error.[14] Whatever the methodological shortcomings of such research, there are in fact substantially good reasons for believing, along with Rendon, [15] that there is a relationship between migration and mental illness. Migration from one sociocultural system to another that is different creates new sources of continuing stress which impinge upon the emotional life of the migrant. However diverse their migratory experiences,[16] first-generation Hispanics are subjected to migration-induced stressful experiences.

One part of the Canino, Earley, and Rogler study[17] of Puerto Rican children in New York City provides a specific example of how such evidence is used to affirm the need for increased mental health care for Puerto Ricans. The authors present various socioeconomic indicators, such as income, education, and unemployment, to show that Puerto Ricans on the mainland are a severely disadvantaged minority group. They are the least educated and least skilled subgroup in the general population; they are hindered by language difficulties; they have the highest unemployment rate, the lowest-paying jobs, the lowest income, and the highest percentage of families living at or below the poverty level. In addition to their low socioeconomic position, Puerto Ricans experience qualitatively new types of stress-inducing life events: the need to learn a new language; the impact of bilingualism upon information processing, memory, cognitive abilities, personality characteristics, and world views; prejudice and discrimination; adaptation to the impersonal terms of a bureaucratized society; the demands of an agitated daily cycle of life in an urban metropolis; and the tribulations of daily interaction with persons outside their ethnic group. The profile of Puerto Ricans developed by the authors coincides substantially with epidemiological models of a population with a high risk for mental illness. Thus, the Puerto Ricans' comparatively high mental health needs are established by inferences. Such inferences are not to be confused with speculation: they are an integral part of the deductive method in scientific predictions.

Nonetheless, there is a commonly recognized need for prevalence epidemiological studies to determine the mental health of Hispanics by measuring dimensions of mental health or by classifying respondents directly according to diagnostic categories of mental illness. Unfortunately, such studies are extremely rare. For example, in a recent systematic review of the literature, Roberts[18] "...identified only three papers, all quite modest in scope..." reporting population-based data of the incidence and prevalence of psychological disorder among Mexican Americans. The findings on the comparative distress of Mexican Americans and other groups were mixed. Roberts' own study in Alameda County, California, suggests that "...the prevalence of psychological distress among Chicanos is at least as high as in the overall population and, in some respects, higher."[19]

With respect to Puerto Ricans in New York City, an earlier major study of residents of midtown Manhattan conducted by Srole et al.[20] found that about half of the 27 Puerto Ricans in its sample were diagnosed as having severe or incapacitating symptoms. While the number of Puerto Ricans in the survey was quite small, this rate was double the rate for any other subgroup in the study. Later evaluation of this study suggested that the differential indications of mental illness may have been due to a bias in the research methodology and to cultural differences.[21] In a survey of more than 1000 residents in the Washington Heights section of New York City, Dohrenwend and Dohrenwend[22] found that Puerto Ricans reported significantly greater numbers of psychiatric symptoms than their social-class counterparts in other ethnic groups. They noted that some of the observed differences may have been due to methodological factors such as cultural differences in response styles, language used to express psychological

distress, and concepts of socially desirable behavior. The root issue is measurement error, or the way in which factors accompanying the measurement of mental illness, but conceptually extraneous to mental illness, intrude upon the observed assessment. Thus, variability in the extent to which respondents are acquiescent or overcompliant in answering questions pertaining to their mental health, or see items in a mental health instrument as representing variable degrees of social desirability, does affect the observed mental health assessments. One conclusion seems almost inevitable: in the absence of well designed community-based epidemiological research which disentangles important sources of measurement error, the case for comparatively high rates of psychological distress among Hispanics rests largely upon the type of inferential evidence just discussed. The inferential evidence in favor of comparatively higher rates of mental health distress among Hispanics is substantially more than plausible.

Whether established inferentially or empirically, the mental health status of Hispanic populations is a core element in the first phase of the clinical service framework presented here. It must be given careful attention in any attempt to understand the Hispanics' utilization of mental health services. At the same time, the rates of mental health symptoms or problems must be kept **analytically separate** from clinic admission rates, rates of specific types of treated mental disorders, or rates of utilization of mental health facilities. To confuse these statistics leads to errors in research and possible misjudgment in mental health policy. Statistics based upon the records of treatment facilities represent the outcome of complicated community-based social, psychological and cultural processes, and more than likely do not have a stable correlation with true prevalence rates across social and cultural groups in the population at large. Were treatment statistics to be taken as a proxy for true mental health rates – thus, disregarding the process separating the two -- biases would intrude into the effort to understand Hispanic mental health service needs. Methodologically, by keeping both as separate components of the clinical service framework's first phase, we can clarify some of the confusion which underlies the literature regarding the hypothesis that Hispanics underutilize mental health facilties.[23] We do not dispute the hypothesis, but we do raise questions regarding the **way** in which limited or partial sets of data have been used to support the hypothesis. The use of the clinical service framework, as we shall see, highlights and illuminates the problem.

To begin with, research on the topic of utilization is scarce, and arguments relevant to true prevalence and patterns of utilization tend to be intertwined. However, a number of studies do conclude that Hispanics tend to underutilize the mental health system. Bachrach's study[24] of Hispanic utilization of mental health services concluded that Hispanics were underrepresented in their admissions to inpatient psychiatric units of state and county hospitals throughout the United States. This study is important because it attempted to compile national data on Hispanic mental health. Since that time, several additional national surveys have been administered by the NIMH with the results generally agreeing with those of Bachrach. Hispanics have been found to underutilize outpatient psychiatric services, private psychiatric hospitals, and the psychiatric services of non-public, non-federal general hospitals.[25] (At the same time, Hispanics were found to overutilize the inpatient psychiatric services of public non-federal general hospitals.) In a more localized study, Karno and Edgerton[26] found that in 1966, Mexican Americans comprised only 3.3 percent of the resident population of California's state hospitals for the mentally ill, at a time when Mexican Americans comprised 9 to 10 percent of California's population. The studies generally support the hypothesis that Mexican Americans underutilize mental health facilities.

In contrast, New York City's Puerto Rican population has been found to have higher rates of reported psychiatric admissions than other ethnic groups in the city. Malzberg,[27] in his analysis of the first admissions of all New York City residents to New York State psychiatric hospitals for the period 1949-1951, concluded that the admission rate was considerably higher for Puerto Ricans than for non-Puerto Ricans. In addition, 58 percent of all Puerto Rican first admissions were diagnosed as schizophrenic, compared to 29 percent for non-Puerto Ricans. Fitzpatrick and Gould[28] replicated this work based upon 1967 hospital admission figures for New York State, concluding that there exists an even greater disparity in the rates of reported first admissions and diagnosed schizophrenia between Puerto Ricans and the general population than was observed by Malzberg.

Several studies using administratively collected data provide additional information on admission rates of Puerto Ricans in New York City. In a study of service delivery to mentally ill residents of the Metropolitan Community Mental Health Center catchment area from 1970 to 1973,[29] the admission rates for non-Hispanic whites were considerably lower than those for blacks and Puerto Ricans: 251.6 Puerto Rican outpatients per 10,000 Puerto Ricans in the population; 158.7 per 10,000 blacks; and 53.6 per 10,000 whites. Similarly, for inpatients, Puerto Rican admission rates were twice those for whites. It was found that a significant portion of this discrepancy was the result of the practice of upper-middle class whites to use facilities outside of the catchment area, while the Puerto Rican population of the area was found to use the local facilities to a greater extent than did either black or white non-Hispanic residents.

Another study conducted at the same time in the Bellevue Catchment Area of New York City[30] found that admission rates for Puerto Ricans and blacks were higher than those for whites. However, black and Puerto Rican clients had fewer outpatient visits per admission than did white clients, suggesting a differential treatment profile for minorities. The basis for this differential may lie partially in the client's attitude toward these services, but it may also be the result of the administrative policies of the facilities, the lack of bilingual personnel, and the absence of culturally sensitive treatment modalities.

Alers,[31] also using New York City figures for admission to all local community mental health and retardation facilities, reported that the total admission rate for Puerto Ricans was approximately twice the rate for non-Hispanics. At the same time, the data demonstrated that the rates for whites were lower than for Puerto Ricans and blacks in all major diagnostic categories.

Finally, Canino et al.[32] constructed a mental health profile of Puerto Rican children, relative to other New York City children, based upon the N.Y. State Dept. of Mental Hygiene's admission form (MS-5). (Although this admission form is the best source of data in New York for group mental health patterns, the authors caution that there are serious methodological problems associated with this source.) The data show that the rates of reported admission interviews for Puerto Rican and black children are considerably higher than those for non-Hispanic white children, with the highest rates found among Puerto

Rican children. In comparison to white children, Puerto Rican children demonstrated a higher frequency of symptoms in the categories of sleep and articulation problems, physical problems, inadequate intellectual development, problems with others in school, anxiety and fear, anger and belligerence, agitation and hyperactivity, and antisocial activities.

It is more than a matter of passing interest – and perhaps an issue for future research – that the research literature tends to characterize Mexican Americans as underutilizers and Puerto Ricans overutilizers, although one study[33] found the rate of treatment of Puerto Ricans to be 3.5 times lower than that for blacks. Does the difference in utilization between the two Hispanic groups reflect higher prevalence rates of mental distress among Puerto Ricans? Or are the barriers to utilization more formidable for Mexican Americans than for Puerto Ricans? Or are there indigenous social organizations in the two Hispanic groups which are creating such differences? We can raise these questions but we cannot answer them: when placed in the context of the clinical service model's first phase, admission rates are necessary but not sufficient in arriving at a meaningful and appropriate conclusion regarding over- and underutilization. Thus, Puerto Ricans characterized as overutilizers, because of their proportionately higher admissions, may be underutilizers relative to their mental health needs. Admission rates, therefore, must be seen in relation to the true prevalence rates of mental health problems in the specific group. Conclusions relevant to over- and underutilization would then be premised upon the magnitude of differences between the two rates, and the admission rate would be expected to be consistently less than the prevalence rate. The larger the disparity between the two rates, the more the underutilization. Research to provide data for the computation of such rates is needed desperately if we are to arrive at sound policy decisions regarding the Hispanics' utilization of mental health service facilities. Such research must be placed in two broader contexts: (1) persons at the lower end of the socioeconomic scale tend, in general, to underutilize mental health facilities,[34] and (2) based on admissions data, Hispanics underutilize all medical facilities in general, including even dentists.[35]

Alternative Resource Theory

The picture becomes more complicated and the need for research even greater when we recognize the fact that in addition to the official mental health agencies and bureaucracies there are a myriad of informal, primary group structures coping with the psychological problems of Hispanics. How well such primary group structures function in coping with emotional distress in comparison to the official mental health system is a moot point. Simply put, we do not know.

But the issue deserves attention in the interest of improving the effectiveness of bureaucratic responses to problems of mental health, and also because it is intrinsically important to the clinical service framework being developed here. In fact, primary group structures may well mediate the relationship between emotional distress and contact with the agency system – the beginning and end of the framework's first phase – and thus be centrally relevant to the varying linkages between true prevalence and admission rates. Historically, the national movement to deliver mental health services on a mass, democratic, bureaucratic scale dates back to the rise of the community mental health movement in the 1960s. Prior to that, state and local efforts to deliver adequate mental health care to economically disadvantaged populations, such as Hispanics, were feeble indeed both in purpose and in impact, and there is hardly need to mention the wretched history of psychiatric asylums in the United States. In contrast, primary group structures relevant to mental health care – the family, the circle of friends and acquaintances, the Hispanic **compadrazgo** (coparent) system, religious and spiritualist groups – are an integral part of the Hispanic culture and function alongside the official agency system. Perhaps one of the most important research and policy issues forming part of the clinical service framework's first phase is the seemingly complicated and as yet unknown system of interrelationships between the experience of psychological distress, contact with help-giving agencies, and such primary structures. Now we shall return to this issue.

The assumption of most of the relevant literature is that Hispanics, as compared to their mental health needs, turn to mental health agencies less frequently than other groups. Hence there is a problem of underutilization. As mentioned before, alternative resource theory and barrier theory emerge as the two explanations of this problem. To view the problem from the perspective of alternative resources is to view it in the context of social organizations. The psychologically afflicted person's help-seeking efforts are seen in the context of institutionally organized interpersonal relations and networks. The person is seen in relation to the family, the circle of friends, neighbors, and acquaintances, the **compadrazgo** (coparent) system, the indigenous folk healing institutions, and the mental health agency system. The broadest question to be posed, consequently, is how does the interrelationship among these institutional groupings affect the person's help-seeking efforts. Is getting help from the family likely to decrease the probability of the afflicted person's seeking help from friends or folk healers or the mental health agency system? Do such institutional groupings represent alternative sources of help or are they conjoined in the provision of help? In comparison to other groups, to what extent do Hispanics use such institutional groupings? Does the pattern of use from one resource to another differ across ethnic group and social class levels? The literature on these questions is confusing, but its size nonetheless attests to the importance ascribed to social organization -- and, hence, to alternative resource theory -- in understanding patterns of mental health utilization. In keeping with this presentation's objective, we repeat that we do not seek a comprehensive review of the social organization, alternative resource literature. Rather, we attempt some observations of the research literature which are specifically relevant to the clinical service framework being presented here.

The family is the foremost institution in Hispanic culture seen as relevant to underutilization. The prevailing view is well presented by Hoppe and Heller:

> Familism is a positive form of social organization that facilitates their (Hispanics') adaptation to the conditions of marginal (objectively alienated) existence and its subjectively alienating consequences. Family ties serve supportive and protective functions against the risk of failure, economic loss, embarrassment, and vulnerability to criticism encountered in the broader society. Such ties serve as a "buffer" between the objectively alienated Mexican American and the Anglo middle-class society.[36]

It is understandable why the family, in the context of the underutilization issue, is viewed almost exclusively as a supportive, help-giving system, since the giving and receiving of help is an integral component of familial bonds.[37] But the generalizing of this view to encompass all issues relevant to mental health creates romantic stereotypes which are scientifically counterproductive and cloud the possibility of studying the family as a source of mental distress. Not all that goes on in Hispanic families is supportive, harmonious, and consensually based. As in other groups, there are also conflict and dissension, bitter recrimination, and violence – a view which is consistent, for example, with the rapid increase of single parent households among New York City's Puerto Ricans.[38] The increasing problems besetting the Puerto Rican family are also suggested by the rising number of divorces in relation to marriages among New York City Puerto Ricans: in 1960 there was one person divorced for every 24 persons married, and in 1970, one person divorced for every 15 persons married.[39]

To some researchers, the major difference between Anglos and Mexican Americans in help-seeking behavior is to be found in the latter group's seeking of help primarily from the family rather than from friends.[40] The difference should be seen, however, in the Mexican American's more exclusive dependence upon the family for help,[41] and the Anglo's disposition to seek help from friends, neighbors, and coworkers. Conclusions on this point differ, however, as the following indicate:

> Mexican Americans as a whole deal with emotional problems in a variety of ways. They tend to know about the neighborhood mental health clinics but these are not utilized to any great extent. Instead, Mexican Americans depend upon physicians, relatives, friends, and religious practitioners for treatment.[42]

> Mexican Americans' main resource, on the other hand, is their extended kin network; there is relatively little support derived from other informal sources.[43]

Although the importance of the family is reaffirmed, the importance of friends or informal sources as help givers remains inconclusive.

Much of the literature on the family in Puerto Rico parallels the findings on Mexican Americans. Rogler and Hollingshead[44] documented how families living in the most impoverished neighborhoods and public housing developments in San Juan, Puerto Rico, enmesh their members in a system of help-giving exchanges. The system incorporates the nuclear family into the extended family, because mutual help crisscrosses blood and affinal relationships. Mutual help, in fact, has the force of a sacred obligatory norm: it is sustained by the double edge of guilt and gratitude. That is, not to help a relative in need evokes feelings of sinful guilt; in turn, to be helped by a relative induces feelings of gratitude. The norm applies through time because the person is bound permanently to his or her family or origin; and it applies through space, because relatives who are separated by geographical distance behave in accordance with the norm. The norm's impact is evident in the finding that at the time the study's data were collected, 88 percent of the nuclear families were either giving or receiving material goods in contacts with their relatives. The type of help given is linked to sex roles in the family: the women provide family-centered, socio-emotional support; the men, the type of help associated with their instrumental roles of linking the family to institutions outside the family.

The findings are not unique. Many studies have documented the family's essential role in the institutional character of Puerto Rican society. The family is central to the island's stratification system, social mobility patterns, and the transition from an agrarian to an industrial society;[45] it mediates between the economic base of communities and socialization patterns;[46] it shapes the social experiences which accrue from socialization;[47] it is the main context of economic consumption;[48] it is an important repository of modernizing impulses to social change;[49] it binds together reciprocal patterns of help in facilitating rural-to-urban migration and adaptation;[50] it mitigates the implementation of middle-class rules in urban public housing developments;[51] it extends itself into the ritual coparent system of compadrazgo to enlarge the scope of its social security function;[52] it is the object of devotion in an overarching system of cultural values;[53] it is the primary setting for the care of the mentally ill;[54] and it even shapes the character of entrepreneurial activities through its system of paternalistic relationships.[55] Despite rapid social change, Puerto Rican society at the root cultural level still centers upon the family and its functions.

Very little is known about the Puerto Rican family in New York City,[56] particularly about its vitality as a help-giving system; how geographical and social mobility affect the system; and how it changes, if at all, from the first to the second generation which now comprises about one-half of the Puerto Rican population in the city. Most speculations, supported by patches of data, favor the view that migration and acculturation are dissolving the extended family system.[57] If this is the case, one would expect significant shrinkage in the effective size of the familial help-giving system.

Similarly, little is known about the role of neighbors and friends as help-givers among New York City's Puerto Ricans. In yesterday's agrarian Puerto Rico, the pattern of mutual aid extended beyond the kin group to include neighbors and friends. The survival of a person or a family often depended upon the fulfillment of such obligations imbedded in tradition. Thus, during the Great Depression, in a community study conducted in a small town located in the central mountainous interior of the island, a sociologist presented the problem of how "it is possible for a family to live on fifty cents a day which is earned only three or four months a year, even where a little money may be earned occasionally at odd jobs."[58] The solution given was that "the survival of a large number of families is dependent upon the aid received from neighbors." Out of 26 typically poor families which were studied, 20 were either giving or receiving help from friends and neighbors. Such exchanges involved labor among workers in agriculture, and even the adoption of children of deceased parents by friends and neighbors. A subsequent study by an anthropologist of a traditional coffee municipality demonstrated that the fulfillment of reciprocal obligations between families is so deeply imbedded in the ideals and practices of the culture that a person's perception of his or her economic standard of living includes the expenses entailed in obligations to neighbors.[59] Other studies suggest, however, that social changes in Puerto Rico are attenuating the traditional bonds of help between neighbors and friends,[60] and that in San Juan the neighboring bond is weakest among families at the bottom of the stratification heap.[61] With little research-based knowledge, speculations favor the view that in New York City such traditional bonds are also attenuated.

Another supportive network commonly cited as important in

traditional Hispanic culture is the **compadrazgo** (coparent) system. Along with material, moral, and spiritual responsibilities of the godparents toward the godchild, functioning as a form of indigenous social security, compadrazgo binds the godparents and the godchild's parents into a pattern of mutual respect and help. Fitzpatrick[62] states that Puerto Ricans in this system "constitute a network of ritual kinship, as serious and important as that of natural kinship, around a person or a group." As a traditional idealized system, the statement is true. However, Rogler and Hollingshead's[63] previously cited study conducted in Puerto Rico found little evidence of a viable, help-giving compadrazgo system; in turn, ongoing research at Fordham University's Hispanic Research Center, focusing upon New York City's Puerto Ricans, shows little involvement by coparents in help-giving exchanges. The same appears to be the case among Mexican Americans.[64] Unless new and more convincing evidence is produced by research, the compadrazgo system among Puerto Ricans and Mexican Americans can more appropriately be viewed as having essentially ceremonial meaning, a ritualized cultural form defining respectful "usted" (formal) relationships between the relevant parties.

Perhaps the most disputed area in the question of alternative sources of support for Hispanics is the role of spiritualist and curandero, the folk healers in Hispanic culture. The subject has received a remarkable amount of attention, ever since the Rogler and Hollingshead study[65] first documented empirically the psychotherapeutic functions of spiritualist sessions in relation to the problems of the mentally ill. The study demonstrated that among persons at the bottom of the San Juan stratification heap, the institution of spiritualism is the most prevalent form of social organization outside the family which helps persons experiencing emotional stress and mental illness.[66] As an ideology, spiritualism assumes an invisible world of good and bad spirits who intrude into human affairs and can be employed by mediums who have developed psychic faculties (**facultades**) to cure illness, arbitrate personal disputes, and explain events incongruous with common sense. As an institution, spiritualism is directly interwoven into the trials and tribulations of perons in the San Juan slums and public housing projects; the medium provides spiritualistic interpretations which are simple, credible, and given in a setting free of the stigma associated with psychiatric treatment at hospitals or clinics. In Puerto Rico persons of modest means almost invariably turn to spiritualism before contacting a psychiatrist or mental health worker. Descriptive accounts of Puerto Rican life in New York City show that in this setting spiritualism as a form of folk psychiatry retains its vitality and functions,[67] and that it converges with the eclectic Christian, African, and West Indian religious practice of **santeria**.

Assertions have been made that folk healers may be more in harmony with Hispanic views of mental illness than traditional therapists,[68] and that therapist and folk healers should work together[69] under some circumstances or whenever feasible.[70] Such proposals, it would seem, assume that folk healing practices are deeply and pervasively rooted in the culture, so that their incorporation into the clinical setting represents nothing more than the extension of indigenous culture into the official mental health system. But the question of how often and how pervasively folk healers are used, and the attitudes of Hispanics toward folk healers, has not been clearly answered, in particular with respect to Mexican Americans. Thus, where one study finds that most people would not use a folk healer,[71] another finds Mexican Americans willing to accept both drugs from a psychiatrist and herbal medicine from a healer.[72] Or, folk healing may be a resource that is used when professional help is not available;[73] a treatment that may be used in conjunction with traditional therapy;[74] or a relatively unimportant factor.[75] One reason offered for this mixed picture is that Mexican Americans may be ashamed of ancient folk healing in the American context and will not admit that they have recourse to it.[76] A second suggestion is that resorting to folk healing is primarily a lower class phenomenon in rural areas and may change in urban and economically advanced communities.[77] On the other hand, the literature that is available for Puerto Ricans – as mentioned before – seems to indicate a somewhat widespread use of folk healing. Puerto Ricans often intertwine their use of spiritualists with therapists;[78] and in many Puerto Rican communities spiritualists are reported to be more numerous than mental health professionals.[79]

In sum, the social organization enmeshing the Hispanics – the family, neighbors, and friends, the fictive coparent system, and indigenous folk healers -- represents alternative resources for coping with emotional problems. To some researchers,[80] these organizational resources represent the most potent explanation for the underutilization of mental health facilities. The explicit argument is that Hispanics first turn to such organizations which are proximate and familiar, and, if no satisfactory solution to the emotional problem results, then as a last resort, they turn to mental health clinics. Two implications derive from this statement. First, if we take the broader meaning of the concept of underutilization – high mental health need conjoined with low utilization – to be factually correct, then Hispanic culture is endowed with organizational strength in coping with the psychological problems of its members. The strength is being utilized to resolve or contain many of the Hispanics' psychological problems after they arise without resorting to professional mental health practitioners. Second, despite such strength, the indigenous social organizations are not capable of fully mitigating the impact of stresses arising from the Hispanics' disadvantaged and marginated status; thus, their high mental health needs. Two functions, therefore, should be kept separate: the indigenous system's capacity to keep psychological problems from arising and its capacity to treat or contain such problems once they have arisen.

If we demand hard, systematic evidence in support of such implications – evidence based upon an organized program of well-executed research, the demand cannot be fulfilled at present because the available research simply does not suffice. Indeed, it has barely begun. We need programmatically organized research focusing upon the triadic interrelationship between mental health needs, patterns of social utilization, and the mediating indigenous social organizations, and how this system of interrelationships is affected by cultural factors such as language differences, the Hispanics' values and their perceptions of mental illness. We believe that this focus is at the core of the clinical service sequence's first phase, the process leading to contacts with mental health agencies. Soon we shall return to the research recommendations to discuss how alternative resource theory fits into the clinical service research framework.

Barrier Theory

The prevailing explanations for Hispanic underutilization are couched, first, in terms of indigenous social organizations which serve as alternative resources to mental health facilities, the theory just discussed; and, second, in terms of barriers which keep

Hispanics away from such facilities. To accentuate the differences between the two explanations, we need only conjecture on the research implications of conceiving indigenous social organizations as "barriers" to agency mental health care, since the alternative resource theory states that such organizations do keep Hispanics away from the mental health system. To accept such a conjecture is to accept an assumption of the absolute, therapeutic preeminence of the mental health agency system; in effect, it is to postulate that the official mental health practitioner commands an exclusive monopoly over therapeutic-relevant experience, skills, and knowledge. According to this argument, anything that keeps the afflicted person away from the agency system or delays contact with the system is, effectively, a barrier to appropriate mental health care. When stated explicitly, the argument is patently unacceptable. The development and implementation of the therapeutic community modality after World War II and the development of the community mental health movement in the 1960s are squarely premised upon assumptions which attribute therapeutic gains to a variety of human interactions, not just those which entail contact with professional mental health workers. Although false, the argument is stated explicitly to counterbalance the tendency to see the problem of Hispanic agency underutilization in a narrow or provincial manner, stripped away from considerations regarding the functions of indigenous cultural resources. Within the broader framework we seek to develop, equally relevant research questions could be raised regarding those barriers which keep persons away from the therapeutic benefits of the indigenous social organizations.

Nonetheless, it is a fact that the research literature, consistently adhering to the mental health agency perspective, formulates the theory only in terms of barriers which keep Hispanics away from such agencies or from professional mental health practitioners. What the theory basically states is that there are many structural incongruities between the assumptions and characteristics of Hispanic culture and those of the mental health system, not the least problem being the prejudice and discrimination leveled at Hispanics. Barrier theory predicts that when such incongruities diminish over time, utilization rates increase; or that in those areas where such incongruities are weak or nonexistent, utilization rates are comparatively higher.

Relevant to the first prediction is the work of Bloom[81] who found that Hispanics in Pueblo, Colorado, went from being underrepresented in regard to inpatient admission in 1960 to being overrepresented in such admissions in 1970, a finding which also may reflect higher mental health needs among Mexican Americans. The increase was attributed to an improved image of the mental health system, an increase in Chicano staff, and the increased availability of financial aid programs.

Research by Trevino et al.[82] is relevant to the second prediction deriving from barrier theory. The purpose of the research was to select an area predominantly inhabited by Mexican Americans and with a mental health center in which structural barriers had been minimized. The community mental health center chosen was in Laredo, Texas, and had a bilingual Mexican American staff indigenous to the area and utilized a sliding-fee scale in charging for services, but never refused service because of inability to pay. These features of the community mental health center reduced language, cultural, and social class differences, as well as economic barriers. Because the city of Laredo is predominantly Mexican American, the effect of being a member of a minority group also was reduced. The researchers found that for the majority of the census tracts, Mexican Americans met or exceeded their expected utilization of mental health services as determined by the ethnic composition of each tract. The study's conclusions were instructive: "...underrepresentation of Mexican Americans in community mental health centers reflects barriers to utilization rather than lower need for service..."[83] Thus, the study supports the predictions stemming from barrier theory. The theory has merit. Now we shall examine some of the barriers to mental health care postulated by the theory.

The Spanish language is the centerpiece of a cultural system which is relevant to the utilization of mental health. Edgerton and Karno[84] found that the language selected by Mexican Americans in interviews, Spanish or English, was the best predictor of their beliefs and perceptions regarding depression, juvenile delinquency, schizophrenia, the inheritance of mental illness, the effectiveness of treatment, and familism. Mexican Americans who took the interview in Spanish were more traditional in their answers than those who took it in English, showing traits usually ascribed to the Mexican culture. The Spanish-language respondents considered depression a more serious problem; were less able to tolerate delinquent behavior and more likely to blame the child for such behavior and recommend more drastic measures for its control; more often considered that mental illness is inherited; more often viewed prayer as an effective mode of treatment; believed that the ill person can best be cured by remaining with his family; and more frequently used the term "nervous condition" or simply "nerves" to describe depression and/or schizophrenia. However, both Spanish and English speaking groups agreed upon the existence and seriousness of the problems and upon the effectiveness of psychiatric and non-psychiatric sources of treatment.

Language differences fit the "barrier" explanation for underutilization. Obviously, when the therapist and patient cannot speak in the same language, the possibility of successful treatment is reduced. Also, the language used is an indication of acculturation and is related to attitudes toward mental health.[85] The relationship between language use and mental health clinic contact may reflect acculturation, awareness of the language limitations of clinic personnel or simply more knowledge of the availability of services.[86]

Clearly then, the importance of language in mental health clinic research is not surprising. Since language is the basic medium in interpersonal communication, the mastery and use of either Spanish or English, or both languages, by Hispanics influence the selection of persons in the ingroup and outgroup with whom stable social relations will be established. The use of Spanish, English, or both languages in a variety of settings and role relationships is also a sensitive indicator of the Hispanic's level of acculturation into American society. For these and other reasons, the importance of language cuts across the sequence of the four phases of the clinical service framework in determining Hispanic utilization of mental health facilities, the evaluation of Hispanic mental health, the effectiveness of the treatments given to Hispanics, and the success of their resumption of customary social roles after treatment.

Along with the Spanish language, a configuration of cultural values attributed to Hispanic culture has emerged as relevant to the utilization of mental health facilities. In this regard, the main values mentioned in the literature are: **confianza**, the value of trust;[87] **personalismo**, trust in the immediate person, not the secondary institution;[88] **respeto**, the value of

respect intrinsically owed to another person;[89] **verguenza** and **orgullo**, the sense of shame and the value of pride;[90] and **machismo**, the pride in manliness and its associated attributes.[91] Other values are also a part of this configuration, such as familism, fatalism, and orientation toward the present. The literature on utilization treats such values largely as descriptive, ethnographic categories to explain some portion of the variance in Hispanic underutilization of mental health facilities. The underlying argument, however, is seldom made explicit: that such values arise from and reinforce the interpersonal matrix of a primary group society based upon face-to-face intimate relationships. Hispanics adhering to such values, therefore, avoid or experience discomfort in their contacts with impersonal, secondary, bureaucratic organizations such as mental health service agencies. Hence, they underutilize the services of these agencies. Presented in its simplest terms, this argument predicts underutilization or diminished contact with **all** bureaucratic services, not just mental health agencies. Plausible as the argument is because of its commendable use of elements in the ethnic culture, no single piece of research has sought to test directly and with appropriate controls the relationships between varying degrees of adherence to this configuration of Hispanic values and rates of utilization of mental health facilities. Were such research to be conducted in the context of the ethnic community's social organization, light would be shed on the important issue of how and when language and values – the two cornerstones of acculturation – affect the process leading to contacts with mental health facilities.

This process is initiated when a person experiencing psychological problems and others in his or her immediate environment perceive the need for help. One would expect that such perceptions, as well as the interpretations which inevitably are made of them, are subject to cultural variability or to differences stemming from levels of acculturation. The findings on this issue, however, are mixed. Some studies find little difference between the ways Anglos and Mexican Americans perceive mental illness,[92] whereas other studies indicate or suggest such differences.[93] Even though Edgerton and Karno[94] see few differences between the two cultures on this point, they still argue that English-speaking Mexican Americans show a higher level of acculturation and thus perceive mental illness in ways more similar to Anglos, while Mexican Americans who speak Spanish regularly had an opposing view. The latter group, for instance, was more likely than the former to believe that mental illness is inherited, with this belief being more characteristic among Mexicans than among Anglos.

Rogler and Hollingshead[95] analyzed the interpretations that Puerto Ricans who had been diagnosed as schizophrenic gave to their illness in a study conducted in the slums and public housing developments of San Juan. The persons diagnosed as schizophrenic viewed their illness as resulting from their being overwhelmed by a variety of symptoms, some of which appear sporadically, and others which disappear only to be replaced by equally tormenting ones. Life problems, social tensions, and conflict were the most common explanations adduced for the illness, while rest and tranquility were desired to allay their overwhelming anxiety and fatigue. In interpreting their own symptoms the schizophrenic persons drew from the folk knowledge of their own Puerto Rican culture. Such interpretations, it would seem, are relevant both to what the afflicted person would be likely to do in seeking help, and to the treatment given to the person by others in the immediate environment. From the foregoing one would infer that if the emotional disorder is seen as social instead of genetic in origin, greater optimism would attend the help-seeking effort. However, if it is classified as mental illness only when it reaches its most severe forms, treatment will be delayed.[96] There is some evidence that Mexican Americans tend to delay treatment until the illness becomes severe,[97] and that illness is viewed as a manifestation of weakness of character, and the need for treatment, as a disgraceful loss of pride.[98]

Hispanic folk cultures, in fact, have concepts which parallel some of the labels in the vocabulary of mental health practitioners. In the study previously cited, Rogler and Hollingshead[99] examined Puerto Rican cultural conceptions of the role of the **loco** or crazy person. The role of the loco is a sharply defined stigma: to become crazy is to lose all socially valued attributes. Locos are seen to behave in ways that are antithetical to the society's value system. The deviant behavior of the loco, therefore, is viewed in a moral context, thus causing the person to attempt to suppress or avoid divulging his or her symptoms. Unable to do so, the schizophrenic person is classified as crazy and, when punished for being a norm-breaker, he or she withdraws from customary social contacts. The study's data demonstrate that culturally defined labels of deviance associated with mental illness have a pronounced impact upon the afflicted person's help-seeking efforts, the treatment he or she received in customary relations, and the deeply rooted reluctance to go to a psychiatric hospital which evokes the stigma of loco.

In addition to cultural and perceptual differences, there is the possibility that socioeconomic differences between patient and therapist will result in underutilization on the part of Hispanics. The lack of rapport between middle-class therapists and lower-class patients is mentioned frequently,[100] as is the general difficulty of middle-class therapists in working with the poor[101] and with the "non-Yavis" people (patients who are not youthful, attractive, verbal, intelligent, and successful) in general.[102] Since the values of patients can affect their utilization of services, so the values of therapists can affect the availability of those services.[103] It is the middle-class character and values of the entire mental health movement that one study sees as one of three major barriers to proper mental health utilization on the part of the poor (the others being fear of institutionalization and attitudes toward mental illness).[104] Here, the authors agree that the literature is replete with middle-class values and orientations toward work, problem-solving, adjustment, conformity, and similar questions. When we consider that blacks have higher rates of utilization than Hispanics, the caution of one study that culture, class, and language interact to cause low Hispanic utilization appears to be well taken.[105] The search for explanations for such complicated interactions should not lead to the neglect of more simple explanations, such as geographic inaccessibility. Mental health clinics are often located at schools of medicine or universities outside the **barrio**.[106] Even this explanation becomes more complicated in the light of survey reports which show that Mexican Americans aware of nearby clinic locations still have low rates of utilization.[107] Perhaps this is linked to the alleged lack of attention personnel in mental health facilities give to the characteristics of their patients,[108] or to blatant racism in patient selection and treatment.[109]

In sum, barrier theory focuses upon the incongruities and tensions between the collective attributes of Hispanics as actual or potential mental health

clients and the procedures and characteristics of the mental health agency system. Accordingly, explanations for underutilization have been sought in cultural (language and values), perceptual, and social class factors.

Conclusions

We started this essay with the purpose of introducing some conceptual order into the clinical service literature on Hispanics. We believe that the overarching clinical service framework, with its four-phase sequence, presented at the beginning of the essay, holds the promise of achieving such an order. The research problems the literature addresses are imbedded in the four phases -- problems associated with contacting the mental health service system, with arriving at a sound or valid evaluation of the client's condition, with adopting an effective therapy to fit the client's needs, and with the client's resumption of customary social roles. The prevailing literature indicates that Hispanics encounter formidable obstacles in each of the framework's four phases, although each signifies a possible problem area for any client regardless of ethnicity.

So far, we have dealt with only the first phase of the framework, which begins with the experience of psychological distress or illness and ends with the contacting and utilization of the mental health service system. At an aggregate or overall level, research relevant to this phase must include at least four components: (1) epidemiological data on the prevalence and incidence of psychological distress in the Hispanic population designated for research; (2) measures of the degree to which the Hispanic respondents are integrated into the indigenous social organizations serving as alternate mental health resources; (3) measures of the Hispanic respondents' degree of acculturation and of the organizational features of the available mental health service facilities, as indicators of the barriers which impede access to such facilities; and (4) Hispanic utilization rates in the available mental health facilities. The reason for including these four components in a utilization study relevant to the first phase of the framework is that the first three components -- the need factor, alternative resources, and the degree of acculturation and agency characteristics – are the major areas upon which the literature converges to explain utilization. If research does not examine the first three components in order to understand the fourth -- utilization, the results will inevitably be ambiguous. For example, underutilization in a logical sense could be due to a low need, the existence of strong alternative sources, and the absence of acculturation barriers. Or, underutilization could be characterized by a high need, weak alternative resources, and formidable barriers. It is only by viewing the interaction of these three factors through comprehensively organized research that we can begin to narrow the margin of ambiguity.

These are the main features of the research problems relevant to the first phase of the framework seen at the aggregate or general level. As we descend from this level of abstraction to an individual level, we can now see with greater clarity that the emphasis placed upon the time factor in the overarching four-phase model must be projected onto the first phase by conceiving it as an attempt over time to cope with psychological distress. However, practically all of the research literature discussed here reveals a surprisingly consistent neglect of the time dimension in the human effort to cope with a mental health problem. It is surprising because the effort to cope, the indicated target of research, is clearly and unmistakably a social process bound by time; yet time plays virtually no role in the research. It is as if the Hispanics' help-seeking efforts had been abstracted out of history and put in a timeless world. The findings of research based upon cross-sectional studies do not capture the time factor. Thus we do not believe there is any possibility of reconciling differences in the findings of the literature reported here or of attaining consistency in the findings of future research unless the research topic is framed as a temporal process.

Let us develop our argument further. We propose that the concept of pathways to the mental health service system is useful because it calls attention to successive contacts from one indigenous social organization to the next or to several at the same time before or while the agency system is contacted. For example, the pathway could be from nuclear to extended family members, intimate friends, folk healers, and then the local community mental health center. The properties of the pathway vary in number, order, and variety of organizations contacted, and in its own duration.

What follows from this proposal is the need to frame research in the clinical services framework's first phase according to the objective and tangible efforts made over time by Hispanics to cope with mental distress. We do not mean to rule out the use of hypothetical questions addressed at Hispanic respondents as to what they would do if certain mental illness symptoms were to be experienced. But hypothetical questions are limited in their use: they bear an unknown and uncertain relationship to what actually does occur, and they cannot be used as proxies. Rather, we need research which delineates pathways concretely in the actual efforts Hispanics make to cope with mental distress. The research could be oriented retrospectively by focusing upon clients forming their first contacts with mental health agencies, or prospectively by identifying the first experience of mental distress and then tracing the coping effort. How the research is in fact oriented will depend upon the specific circumstances.

How does barrier theory fit the approach being proposed? Simply put, barrier theory provides hypotheses which attempt to explain how the help-seeking effort described by the pathway – or by the sequential use of alternative resources, which is the pathway's equivalent -- is either suppressed or expedited in moving toward contact with the mental health agency system. Let us provide a specific illustration from **Trapped: Families and Schizophrenia**[110] of how the perception of mental health distress – which, as we have seen, is treated in the literature as a barrier among Hispanics creating underutilization -- influences the help-seeking pathway. Mrs. Badillo, a 37-year-old woman, began suddenly to have violent fits and seizures in which she would collapse on the floor, her limbs trembling, as she gasped for breath and moaned in a loud, sorrowful voice. Her symptoms conform to what has been described as the Puerto Rican syndrome, an **ataque**.[111] After a long mental health evaluation, a psychiatrist on the research team, not part of the service agency system, diagnosed her problem as that of hysterical hyperkinetic seizures. Mrs. Badillo, however, did not take her problem to a professional mental health worker. First, she turned to her husband and then to her neighbors, all of whom advised her that the problem had a spiritual cause. Second, she went to a spiritualist for consultation.

> Yes, I went to consult a spiritualist to see what the attacks meant. The medium told me that there was a young man who was in love with me. The mother-in-law of this young man bewitched me through an evil spirit. This evil spirit takes me over in a violent way.

> Do I believe the medium? Of course I do! She described many events in my life that were true. When I see the mother-in-law of this young man I get an attack. This proves that the medium is right.[112]

Since the spiritualist's interpretation of the problem satisfied Mrs. Badillo, she sought no help from persons outside the indigenous organizations. In this case, the pathway was comparatively simple and short, from husband to neighbors and then to the spiritualist, all of whom framed the problem according to spiritualist ideology. The way the problem is perceived – which is one of the variables in barrier theory – conditions the pathway.

Let us pursue the illustration a step further. Had Mrs. Badillo's problem been perceived to have material cause in addition to a spiritual cause, she probably would have consulted with both a medium and a professional mental health practitioner, or one person commanding both sets of skills, as the following quote would suggest. The prevailing view of the **Trapped** respondents regarding the division of labor between spiritualist and psychiatrist (or mental health practitioner) was clearly stated by one person.

> Mediums understand things that the doctor-psychiatrist does not; that is, if the doctor is not a spiritualist. If psychiatrists were to know about spiritual matters they would be doctors in the broadest sense of the word. When the doctor does not know about spiritual matters, he should consult with a spiritualist, and in this way they could come to an agreement. Spiritualists would treat the spiritual part of the problem and thereby rid the individual of possible evil spirits. Psychiatrists could treat the nervous system, if this were affected. There would be much success then.[113]

The opinion quoted above allows us to make the point that awareness and acceptability of the professional facilities are factors that bear an immediate relevance to the pathway described. These components, together with accessibility and availability, are suggested by the National Institute of Mental Health for assessing the utilization of community mental health centers.[114] Thus, the example of Mrs. Badillo indicates an awareness of professional mental health services, which, however, were not considered acceptable because the problem was not perceived as having its origins in the nervous system. Her perception of the problem as a spiritual one detaches her from the professional system because she is rooted in the indigenous system. Such perceptions, influential in relation to the pathway, are drawn from culturally based ideologies of mental health. The perception of the mental health problem acted as a barrier toward the utilization of the professional system.

Freidson's typology[115] of lay referral systems sheds light on the issues being discussed. What Freidson conceives as a lay referral system is what we have been describing as the pathway through social organizations. Thus, lay referral systems should be understood as consisting not only of persons and groups providing referrals, although this component is included, but also as an interpersonal system that diagnoses and provides treatment. His typology is based upon the combination of two elements: (1) the congruence or incongruence between the lay and professional culture according to elements we have previously described such as language, values, and the perceptions of illness and of appropriate treatments; and (2) the structure of the lay referral system which may be loose and truncated or cohesive and extended. If the structure is loose and truncated, the persons are left on their own in the consultation process or they consult only with members of their immediate families. If it is cohesive and extended it reinforces the beliefs and values of the people. The combination of the elements yields four types of lay referral systems. For our purposes the most important type is the one which combines an incongruity between lay referral culture and professional medical culture, on the one hand, and a lay referral structure which is extended and cohesive, on the other hand. In this type, the help-seeking effort occurs as a sequence of steps through the extended and cohesive lay referral system (the indigenous social organizations), before contact is made with the professional system. Delays in contacting the professional system or the avoidance of the system are due to the availability of an extended and cohesive group of help givers, and to the fact that membership in such a group reinforces the cultural incompatability between the lay and professional system. This conception of help-seeking as a social process highlights the temporal dimension we already have emphasized.

The Hispanics' efforts to cope with psychological problems unmistakably fit this type of lay referral system as is evident in the literature we have reviewed, and in other literature as well.[116] Not only do they fit in a descriptive sense, but the predictions which derive from this type of lay referral system conform to the Hispanic's low utilization rates of mental health services. The studies previously discussed,[117] which have shown that the use of bilingual, bicultural staff and of paraprofessionals indigenous to the ethnic community reduces barriers and increases utilization, can be understood in the context of Freidson's general typology of lay referral systems: When the lay referral systems (or the indigenous social organizations) are socially or structurally intertwined with the mental health system and the cultural differences between the two are thus reduced, utilization rates among Hispanics increase. The professional system reaches out to the cohesive and extended lay referral system to increase its accessibility and to assimilate elements of indigenous or lay culture in the interest of attracting persons to use it services.

In sum, alternative resource theory and barrier theory can be integrated to provide a more dynamic and comprehensive framework for research focusing upon the clinical service framework's first phase. The use of such a framework should capture more accurately and extensively the Hispanic experience of mental health service utilization, and thus improve mental health policy and practice affecting the Hispanic community.

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HISPANIC RESEARCH CENTER: RESEARCH BULLETIN

The HRC is directed by Dr. Lloyd H. Rogler, Albert Schweitzer Professor in Humanities at Fordham University.

The HRC operates under a research grant (1 R01 MH 30569-03) from the Minority Group Center of the National Institute of Mental Health. The Research Bulletin invites comments and news items from its readers. Let us know what topics you would like to see in future issues. Address correspondence to:

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RESEARCH BULLETIN
HISPANIC RESEARCH CENTER
FORDHAM UNIVERSITY
BRONX, NEW YORK 10458

April-July 1982 Vol. 5-Nos. 2 & 3

A New Conceptual Framework For Mental Health Clinical Service Research On Hispanic Populations

(Continued)

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The last issue of the *Research Bulletin* (October 1981-January 1982) presented the first part of a conceptual framework for mental health clinic service research on Hispanic populations. Clinical service research was viewed as spanning a hypothetical temporal sequence beginning when a person experiences mental or emotional distress, and ending after official mental health providers have attempted to deal with the problem and the person resumes his or her customary social roles. This issue of the Bulletin is a sequel to the last issue for it completes the presentation of the conceptual framework. Both issues of the Bulletin, therefore, should be viewed as companion pieces.

Two modifications have been introduced into the conceptual framework since the publication of the last issue. First, the framework has been further refined so that the four phases of the temporal sequence have been increased to five. Presently, we shall explain this change in detail. Second, to give each sequence a tangible reference and more specific meaning we present illustrations of research projects fitted into each of the sequences. The research projects represent initiatives the Hispanic Research Center is planning to undertake during the next five-year period of its life if adequate funding can be secured.

The reader will recall that the hypothetical temporal sequence of clinical service research originally was divided into four phases. There are compelling logical reasons for increasing the sequence to five phases. What was originally the first phase -- utilization of mental health facilities -- has been separated into two phases: psychiatric epidemiology and utilization. Each phase is broad in scope. To treat them as one phase unnecessarily increases the complexity of the research questions to be posed, and could lead to confusion.

Psychiatric epidemiology, constituting the first phase of the refined framework, provides empirically based measures of the true prevalence and incidence of mental health problems across demographic categories and sociocultural groups. It is oriented toward uncovering factors relevant to the sociocultural and economic origins of mental health distress. Psychiatric epidemiology also provides measures of the need for mental health services. On the other hand, the framework's second phase focusing on utilization assumes the presence of mental health distress and poses questions relevant to the help-seeking efforts designed to allay such

distress. The last issue of the *Research Bulletin* examined the literature on Hispanic utilization of mental health facilities and argued that utilization research should include four components: (1) epidemiologic data on the prevalence and incidence of psychological distress in the Hispanic population; (2) measures of the degree to which Hispanics are integrated into the indigenous social organizations serving as alternative mental health resources; (3) measures of the Hispanics' degree of acculturation and of the organizational features of the available mental health facilities, as indicators of the barriers which impede access to such facilities; and (4) Hispanic utilization rates in the available mental health facilities. The relationship between mental health needs as indicated by epidemiologic data (1) and utilization rates (4) is mediated and affected by the degree to which help-giving indigenous organizations are used (2) and the barriers which separate Hispanics from mental health facilities (3). Issues relating to the etiology of mental distress should be kept clearly separate from the complex issues relating to the utilization of mental health facilities. Thus the need for the distinction between Psychiatric Epidemiology as Phase 1 and Utilization research as Phase 2 of the framework.

The relevant literature supports such a distinction. For example, Dooley and Catalano[1] (1980) present a compelling discussion of the relationship between economic change and psychological disorder which parallels our distinction between Phase 1 and Phase 2. The authors posit a connection between aggregate economic change and disorder via multiple direct and moderator paths. Principal direct linkages are: the causation of life events changes by economic change, the causation of symptoms by stressful life events, the translation of symptoms into a demand for services, and the effect of economic change upon individual symptoms without mediation of life change. Moderator variables include: individual adaptation to life change, personality variables, decision to enter therapy, availability of services, family tolerance, community tolerance, and social support. Dooley and Catalano's treatment of direct pathways roughly corresponds to what the Hispanic Research Center's framework identifies as psychiatric epidemiology, albeit with a strong emphasis placed upon the importance of economic events. The use of the moderator variables corresponds to the framework's second phase of utilization, in that the question of what might intervene between experienced emotional distress and utilization of services is specifically addressed.

Thus, the five-phase conceptual framework comprises the following: The first phase encompasses psychiatric epidemiology which seeks to determine the true prevalence and incidence of mental health problems of Hispanic populations, in relation to issues of etiology. The second phase begins when a person experiences mental or emotional distress and initiates help-seeking efforts which may lead him or her to contact official mental health service providers. The third phase involves attempts by such providers to evaluate or diagnose the client's psychological condition. The fourth phase begins when official mental health providers attempt to deal with the problem through therapeutic interventions. The fifth and final phase involves the termination of treatment and the client's post-treatment rehabilitation and resumption of customary life roles.

Although the first two phases of the conceptual framework were amply discussed in the previous issue of the *Research Bulletin*, we shall return to them briefly here in order to present the research projects which the Hispanic Research Center is considering to undertake in each of these phases. This is followed by a more detailed discussion of the third, fourth, and fifth phases in order to complement and complete the material presented in the last issue.

Phase 1: Psychiatric Epidemiology

In this phase, the HRC proposes to undertake a psychiatric epidemiologic study called "Migration and Mental Health: Hispanic Diversity in New York." The study will examine the processes through which Hispanic migrants to the New York area become situated in the social structure of the United States and how variations in their socioeconomic and family life cycle histories related to the migration experience influence dimensions of mental health directly, and indirectly through stressful life events, social support networks, and acculturation. Specifically, the study will collect detailed data on three dimensions of mental health -- anxiety, depression, and self-esteem -- that are of both theoretical and practical importance in terms of the problems most frequently presented by Hispanics to community mental health centers.[2] This study displays cultural sensitivity to issues of measurement error; substantively, by explicitly incorporating multiple dimensions of the concept of acculturation into the study; procedurally, by including measures of acquiescence, social desirability, and adaptational requirements of life events to test for culturally patterned response sets; and in the collection of data, by the use of a back-translation procedure in developing the instruments and by the use of bicultural/bilingual interviewers from the diverse Hispanic groups to be studied.

The significance of this study, however, extends beyond the measurement issue and the scarcity of research in this area, discussed in the previous issue of the *Research Bulletin*. An integrated dynamic theoretical framework, derived from three major bodies of mental health literature, is developed that will analyze how the processes through which Hispanic migrant groups become situated in the social structure of the United States relate to the above-mentioned dimensions of mental health directly and indirectly.

Phase 2: Utilization of Mental Health Facilities

Hispanic utilization of mental health facilities is the central problem of research in the conceptual framework's second phase. In this phase the HRC proposes to undertake a research initiative called "Utilization of Mental Health Service Systems among Diverse Hispanic Groups." This study will examine the sequences of mental health related coping behaviors of diverse Hispanic groups -- Puerto Ricans, Cubans, Colombians, and Dominicans -- along with samples of black and native white non-Hispanics. It will attempt to integrate epidemiological data on the prevalence of psychological distress in the Hispanic population, alternative resource theory and barrier theory -- the major areas upon which the literature converges to explain utilization -- into a more comprehensive examination of Hispanic utilization of mental health services. Therefore, this research initiative includes the four components the literature review presented in the last issue of the Bulletin signalled as important: (1) a general measure of mental health need in the population designated for research; (2) measures of the extent to which survey respondents are integrated into the indigenous social organizations which may potentially serve as alternative mental health resources; (3) measures of the Hispanic respondents' degree of acculturation and of the perceived organizational features of the available mental health facilities, which may or may not be perceived as barriers to service utilization; and (4) documentation of utilization during a specified period of time of the referral pathways of clients currently receiving mental health treatment. Only by viewing the interaction of the first three factors through a comprehensively organized study will we be able to effectively assess the meaning of utilization statistics. To achieve this goal, detailed survey data will be collected addressing each of these dimensions.

Phase 3: Psychiatric Assessment of Hispanics

Phase 3 involves the mental health assessment of Hispanic clients who have reached a treatment setting. Here we shall briefly consider the diagnostic process and discuss selected surrounding issues, problems, and possible diagnostic alternatives.

A client's early contacts with a mental health agency are likely to be diagnostic in nature, whether the assessment performed is formal or informal, brief or extensive. The procedure might include a mental status examination, an interview in which the client's present contact with reality and personal orientation are assessed. Psychological tests might be administered, such as an individual intelligence test (WAIS-R, WISC-R, Stanford-Binet), projective techniques (Rorschach, Thematic Apperception Test, drawings) in which a client "projects" aspects of his personality onto ambiguous stimuli, a psychometric paper and pencil personality test (MMPI), or a neurological screening device. A social history is taken to place test and interview data in context. At the end of this process, a diagnosis is assigned, a disposition made, and a treatment plan developed.

The question of whether the instruments used in assessment and even the assessment process itself are culturally biased has been hotly debated, but the presence of between-group differences on tasks and qualities attributable to the process of assessment is indisputable. These differences suggest that something other than the qualities which the tests are designed to measure is at issue. In the early 1930's Sanchez[3] called attention to vocabulary and other linguistic differences between Hispanic children and non-minority children. More recently, differences have been reported in diverse comparisons between members of Hispanic and other ethnic groups. Durett and Kim[4] found that Mexican American preschool children were less behaviorally mature than their Anglo counterparts; Haberman's field studies[5] indicate that Puerto Ricans consistently tend to report more psychiatric symptoms than other groups; Kagan and Romero[6] found that nonadaptive, assertive behavior was more prominent among Anglo than Mexican American children. LeVine and Padilla[7] list a number of personality tests on which Hispanics' performance differed from that of other ethnic groups. They concluded that projective tests tap personality factors as they vary with cultural and social milieu, and that cultural ideology and acculturation level may affect choices made on objective personality measures.

Although Korchin[8] discusses alternatives, assessment typically involves the implicit or explicit comparisons of the behavior or response of the examinee with that of other people. On intelligence and psychometric personality tests, an individual's performance is compared with group norms. Hence, a Hispanic client may appear at the lower end of the non-minority group norms, yet be within or close to the average range for his or her own ethnic group. The impact of this on people's lives can be dramatic. As Reschley, Mercer, Garcia and McClelland[9] show, a large number of minority children are overclassified as mentally retarded and emotionally disturbed.

On more open-ended tasks, such as interviews or projective tests, clinicians may make use of group norms and/or make a qualitative comparison of an individual's performance with a generalized view of a healthy person. In any case, the more performance diverges from the clinician's view of normal, the more noteworthy it becomes. Hence, the question of what frame of reference is being used is of the utmost importance for minority group clients, since norms have meaning only if they are appropriate for the individual being considered. Not surprisingly, a prominent theme in the literature of minority assessment is the need to develop appropriate norms.

Cole's discussion of bias in testing[10] is based on the premise that questions of bias are questions of validity -- whether the tests accurately measure what they purport to measure. Based on her review, she concluded that differential predictive validity and bias in internal test structure have not been established for the tests and groups studied. It is noteworthy that her discussion revolves around a comparison of black and white groups, and that LeVine and Padilla's review points to differences in obtained test results from blacks and Hispanics. However, Cole's distinction between the issues of validity and whether certain tests should be used, even if valid, is well taken. She points out that the consideration of the possibility of test bias arose from concern with equitable treatment of special groups within our pluralistic society, and that these broader issues of social policy and implementation cannot be reduced to a matter of test bias. One of the major questions which she raises is how we should deal socially and educationally with people for whom English is not a first language.

The flagrant difficulties involved in testing a non-English-speaking client cannot be denied. When a Hispanic client who speaks no English is being assessed by an English-speaking diagnostician, a translator's services are needed. As Marcos[11] pointed out, any available person (a family member or a bystander) may be pressed into service. Interpreter-related distortions may give rise to important misconceptions about the patient's mental health status. These distortions are most frequently associated with defective linguistic and/or translation skills of the interpreter; the interpreter's lack of psychiatric knowledge; and the interpreter's self-imposed role and attitude toward either patient or the clinician. In a poignant article, Sabin[12] discussed two case histories of Spanish-speaking clients who had been evaluated and treated by English-speaking clinicians by use of translation. Sabin suggests that these patients' emotional problems were selectively underestimated and their anxiety inadequately translated. When the client appears able to participate in an assessment process conducted in English, another set of problems is posed. In a compelling study, Marcos et al.[13] discovered that interviews conducted in the client's non-preferred language yield a clinical judgment of greater pathology. This finding will be further developed and explored in the first research initiative the HRC proposes to undertake in this phase (see below).

Important as the issue of language is, it is surrounded by the still larger issue of biculturalism. Mercer[14] provides a discussion of the impact of biculturalism on the assessment of Hispanic clients. One of her major conclusions is that the IQ tests used by psychologists measure, among other things, the extent to which an individual's background is similar to that of modal American society. This conclusion could be investigated with respect to other types of tests as well.

A number of alternatives to the system of assessment as it now exists have been proposed. Mercer[15] discusses a number of approaches that aim to be neither racially nor culturally discriminatory. She considers that it is virtually impossible to have culture-free tests since all learning takes place in a sociocultural context. Alternatives include modification of existing tests (translating, rewriting, etc.) and culture-specific tests developed for each sociocultural group.[16] Mercer also points out that such tests face the same problem of being tied to a single ethnic group, albeit in reverse of the Anglocentric tests currently in use. Mercer's own alternative is a System of Multicultural Pluralistic Assessment (SOMPA)[17] designed to assess the current level of functioning and the potential of low SES children from Anglo, Chicano, and black cultural backgrounds. She discusses how children can be considered in comparison to both standardized norms for tests and those developed for the sociocultural group to which the individual belongs. Although she has focused on assessment of intelligence, these principles could also be investigated in relation to personality assessment.

A variation of the culture-specific approach is to gear the test not to a particular ethnic

group but to a more general group of clients who have proved less than responsive to traditional tests. For instance, Costantino[18] of the Hispanic Research Center is in the process of developing a promising projective technique called TEMAS (Tell Me-A-Story), a TAT-like method depicting ethnic minority figures, cultural themes, and urban backgrounds. The HRC's second research initiative in this phase of the conceptual framework will attempt to evaluate the usefulness of this test in assessing the personality functioning of Hispanic children (see below).

Research on the assessment of Hispanic clients points to the many topics which warrant further exploration. Representative topics will be mentioned briefly. LeVine and Padilla's review[19] of the area of self-disclosure among Hispanics, consistently at a lower level than that for Anglos, has important implications for the diagnostic process, since clinicians may find it difficult to obtain information of a personal nature. Some of the studies are qualitative and descriptive in nature. Rogler and Hollingshead[20] and Grace[21] present a portrayal of an *ataque nervioso* which may occur when the Hispanic individual is confronted with an overwhelming catastrophe. If the *ataque* is separated from its cultural context, major pathology could be inferred from the screaming, falling, lack of communication, and agitated motor movement evidenced by such individuals. The subject of stereotyping has also received considerable attention among both the general population[22] and clinicians.[23] These considerations suggest that client's ethnic group affects clinical judgment about that client.

In their study of Hispanics, blacks, and whites in a psychiatric hospital in the South Bronx, Baskin et al.[24] also found a relationship between the patient's ethnicity and psychiatric diagnosis. Hispanic psychiatric patients were more frequently diagnosed as having depressive/affective disorders, transient situational disturbances, and non-psychotic disorders in comparison to blacks and whites. In another study, the Baskin group[25] explored diagnostic differences between men and women of the above three ethnic groups. The most prevalent diagnoses among the total group of Hispanics were non-psychotic disorders, transient situational disturbances, alcoholism, depressive/affective disorders, and schizophrenia. Proportions differed by sex within the ethnic group. For instance, more men carried the diagnosis of alcoholism than women; while more women than men were diagnosed as having non-psychotic disorders.

The evaluation of mental health, thus, is the outcome of a complicated process in which interview language and interviewer ethnicity play an important role. Assessment of this role will be the focus of the HRC's first research initiative in this phase dealing with culturally sensitive evaluation of Hispanic clients. As we have seen, interest in the impact of bilingualism and biculturalism on psychiatric diagnosis is not a recent development. As far back as the 1930's Velikovsky[26] questioned whether a newly acquired language could assess the unconscious, and later Buxbaum[27] expressed a related concern over the effect of a second language on the formation of the ego and superego. Similarly, subsequent reports have focused on the role of language in facilitating and disrupting the therapeutic process,[28] while others have dealt with linguistically differential responses to drugs,[29] electro-convulsive therapy,[30] and aphasia.[31]

One area that has attracted much attention is the effect of bilingualism on psychiatric diagnosis.* In a clinical interview does the choice of language per se influence psychiatric evaluation? Del Castillo[32] described several clinical episodes in which Spanish-speaking patients appeared overtly psychotic during native-tongue interviews, but much less psychotic when interviewed in English. On the other hand, Marcos and his associates[33] reported that Spanish-speaking schizophrenics were evaluated as higher in pathology when interviewed in English than when interviewed in Spanish. In these experimental studies, videotaped sessions of patients being interviewed in both English and Spanish (on two separate days) were evaluated by clinicians using the Brief Psychiatric Rating Scale (BPRS).[34] Marcos et al. quite correctly used experimentally blind evaluators, i.e., clinicians who rated the videotapes independently of any knowledge about the purpose of the study. Furthermore, the evaluators did not have direct contact with patients, precluding any direct influence on subjects' behavior. Efforts were also made to establish interrater reliability of clinical judges. However, as Marcos acknowledged,[35] there remained at least one major source of experimenter bias: the English sessions were evaluated by English-speaking clinicians. Thus, the reported results may have been attributable to either the interview language or a possible ethnic bias of the clinician. Such biases are well documented. Gross, Knatterud, and Donner[36] state that as the sociocultural distance between the clinician and patient increases, diagnostic errors increase and disposition becomes less specific. For example, a white female brought to a psychiatric emergency room is more often diagnosed as neurotic and referred to outpatient treatment, while a non-white female is more often classified as schizophrenic and treated in the emergency room. Similarly, Bloombaum, Yamamoto, and James[37] interviewed therapists about stereotypic attitudes toward Mexican Americans, Chinese Americans, blacks, Japanese Americans, and Jews, and found that of these, Mexican Americans were the most likely to be culturally stereotyped.

Recognizing this confounding factor in Marcos' research, Price and Cuellar[38] investigated the effects of interview language on diagnosis but held evaluator ethnicity constant and bilingual Hispanic clinicians evaluated both the English and the Spanish sessions. The results were the opposite of those obtained by Marcos et al.: more pathology was detected in Spanish than in English.

Though Price and Cuellar eliminated this source of experimenter bias and obtained different results, their study cannot be considered an adequate refutation of Marcos' work. This is mainly because Price and Cuellar made several procedural changes in their replication and their results may be attributable to any of the factors they changed. One likely source of variation between the studies is the type of patients studied. While Marcos et al. studied recent admissions to a psychiatric hospital, Price and Cuellar's patients averaged 9.7 years of hospitalization. It is probably safe to assume that Price and Cuellar's patients were well accustomed to being handled by psychiatric personnel. Marcos et al.'s patients, on the other hand, were probably less experienced and any language difficulties they had in English may have been exacerbated by the nervousness of being in an unfamiliar environment. Further, Marcos' patients were admitted to Bellevue Hospital, a large city hospital in New York; Price and Cuellar's patients were being treated at the Bilingual/Bicultural Unit at the San Antonio State Hospital, apparently, a culturally sensitive institution. It is impossible to determine at this point if these differences in sample selection influenced the results of the studies.

Another procedural difference is the rater's knowledge about the study. Price and Cuellar state that the raters were not informed about the purpose of the study, i.e., they were supposedly experimentally blind. In fact, however, Price and Cuellar's procedure rendered this control virtually impossible as each subject's English and Spanish interviews were rated by the *same* evaluator. Since BPRS is a very subjective instrument, the question arises: How were these subjective ratings influenced by the fact that the clinician evaluators could not have been naive to the purpose of the study? This is a source of experimenter bias not present in Marcos' work.

Another type of experimenter bias introduced by Price and Cuellar is the type of

* Portions of this section were published in the *Hispanic Journal of Behavioral Sciences* (Vol. 4, No. 1, 1982) under the title "Research on the psychiatric evaluation of the bilingual patient: A methodological critique" written by Carol A. Vasquez.

interviewer used (the clinician sitting in the examining room with the patient). While Marcos et al. had the questions recorded on audiotape (with an "interviewer" present who interacted minimally with the patient), Price and Cuellar had the interviewer recite the questions directly to the subject, and in some cases, subjects were prompted by the interviewer. Though it can be argued that Price and Cuellar's approach was less artificial than Marcos', it is natural to wonder if the interviewer's behavior in Price and Cuellar's study influenced patients' behavior. Again, the interviewer could not have been experimentally naive since patients were interviewed in both English and Spanish.

Furthermore, the ethnicity of the interviewer (i.e., the person sitting in the room with the patient) varied in Marcos' studies but not in an experimentally systematic manner. It is possible that cultural attributes of the interviewer may have directly influenced the patients' behavior. Thomas,[39] for example, contends that patients are sensitive to negative stereotypes exhibited by the clinician with respect to race and socioeconomic status and that patients' appropriate negative reactions may lead to a distortion of the diagnostic and therapeutic process. In a similar vein, Carkhuff and Pierce[40] reported patients most similar to the race and socioeconomic status of the therapist were the most likely to engage in deep self-exploration during an initial clinical interview, while patients most dissimilar explored themselves the least. Therefore, this factor will be systematically manipulated in the first research initiative the HRC proposes to conduct in this phase of the conceptual framework.

This research initiative entitled "Impact of Bilingualism and Biculturalism on Psychiatric Diagnosis," will experimentally investigate the effects of interview language on psychiatric diagnosis. With one group of investigators reporting greater pathology ratings in English[41] and a second group reporting greater pathology ratings in Spanish,[42] there is a definite need for clarification. In sum, while attempting to minimize sources of clinician bias, we propose to examine the effects of both interview language and interviewer ethnicity on psychiatric evaluation.

The second study the HRC proposes to undertake in the third phase of its conceptual framework for clinical services research – "Assessment of the TEMAS Projective Test for Use with Hispanic Children" – is to identify aspects of the TEMAS projective personality test content that are relevant to particular Hispanic subcultures and, using this information in scoring projective test protocols, to establish the validity of the TEMAS test relevant to Hispanic culture for assessing personality functioning and mental health status in Hispanic children.

The cultural appropriateness of using with minorities instruments that have been standardized on primarily white and middle-class groups has been a prominent issue of long-standing debate in the field of psychological testing. While some attempts have been made to develop culturally sensitive intelligence and personality tests for blacks[43] as well as for Hispanics,[44] unfortunately, these instruments have not withstood critical psychometric evaluation.[45]

With respect to projective personality tests, minority children, as we have seen, have been evaluated as less verbal, less emotionally responsive, and more psychopathological than their non-minority counterparts.[46] Challenging these findings, several investigators have argued that urban minority children are not inherently deficient, inasmuch as traditional standardized tests fail to accurately measure the intellectual, cognitive, personality, and affective functioning of minority children.[47]

An early attempt to develop a culturally relevant projective test was made by Thompson,[48] who changed the white characters of Murray's TAT[49] into black characters, based upon the notion that the closer test stimuli resemble the examinee, the more the examinee identifies with the stimuli, hence the greater likelihood of test stimuli eliciting meaningful responses.[50] Preliminary findings indicated that black college students showed an increase in verbal productivity in response to the black TAT; however, subsequent studies failed to replicate these results.[51] Murstein[52] later attributed the apparent lack of validity of the black TAT to the fact that (1) blacks are not a socioeconomically homogenous group; (2) a high degree of similarity between the test stimuli and the testee tends to increase ego defensiveness; and (3) simple verbal productivity seems to be an inadequate criterion of test validity. However, other investigators[53] have suggested that the black TAT lacked validity for blacks because (1) only TAT chaacters were altered, while original TAT backgrounds and themes were retained; (2) college students were not representative of the general black population; and (3) the instrument was introduced at a time when prejudice against blacks was higher than today.

Notwithstanding the early discouraging findings with regard to the black TAT, Cowan and Goldberg[54] studied the effects of race and sex of TAT characters on achievement motivation of black males and females using original TAT characters with altered racial characteristics. Cowan and Goldberg reported that black characters stimulated higher verbal productivity and achievement motivation than white characters. Similarly, Baily and Green[55] compared Murray's TAT, Thompson's TAT, and an experimental TAT developed to reflect black features in a more culturally congruent manner than previous attempts. These investigators found that black males clearly discriminated the black figures of the experimental TAT, characters were judged more like "people in general," and verbal productivity was enhanced. Thus, Bailey and Green concluded that projective test stimuli culturally and racially congruent with the examinee were valuable in enhancing the meaningfulness of the response.

In the light of the compelling need for a culturally sensitive projective test for Hispanics, the TEMAS (Tell-Me-A-Story) was developed as a thematic apperception test consisting of pictures depicting interactions among urban ethnic minority figures, minority cultural themes and symbols, and urban backgrounds.[56] The instrument was developed from the notion that projective test stimuli ought to be sensitive to the cultural background of the testee in order to elicit sufficient verbal productivity and meaningful response. The pictures were developed by a clinical psychologist in collaboration with a professional artist to accurately represent the ethnic features of Hispanics in realistic urban settings. The stimuli depict situations involving underlying psychological conflict (e.g., complying with a parental errand vs. playing with peers) in order to elicit responses reflective of adaptiveness of ego functioning. TEMAS stimuli are presented in full color to further enhance the realism of the situations depicted in the pictures. Each TEMAS picture was developed to "pull" particular ego functions, such as delay of gratification, achievement motivation, self-concept of competence, or anxiety and withdrawal, representing a total of nine basic ego functions and 39 subfunctions. The psychometric value of TEMAS with respect to traditional projective tests such as TAT, CAT, Rorschach, Draw-A-Person, and House-Tree-Person rests on the following factors: (1) the use of chromatic, nonambiguous and familiar stimuli to elicit diagnostically meaningful stories; (2) the representation of both negative and positive polarities of affects, cognitions, intrapersonal functioning and interpersonal relationships; (3) the assessment of the interaction between affective, cognitive, intrapersonal, and interpersonal factors focusing on both motivational and overt ego function levels; and (4) the use of an objective scoring system in analyzing TEMAS stories, which will yield both normative data and clinical-intuitive understanding of personality and degree of psychopathology.

In one recent study, Costantino, Malgady, and Vazquez[57] found that TEMAS enhanced verbal productivity relative to the Murray TAT, and that examinees were likely to switch

from an English response on the TAT to a Spanish response on the TEMAS, but not vice versa. While preliminary evidence of the appropriateness of TEMAS for Hispanic children is encouraging, additional research is required to establish what specific features of TEMAS' complex stimuli have psychometric and clinical utility in psychodiagnosis and evaluation.

Phase 4: Therapeutic Modalities for Hispanics

The fourth phase of the HRC's conceptual framework focuses upon the development and evaluation of culturally sensitive therapeutic modalities for use with Hispanic clients. Here we shall briefly discuss major issues in this phase of research, such as assignment to treatment, type and duration of treatment, therapy process and outcome.

The first major issue in this phase of the conceptual framework, simply put, is what sort of patient gets assigned to which type of treatment. Since the question of how Hispanic clients are assigned to treatment has received little direct attention, the body of research concerning low-income clients is worthy of consideration. There is ample documentation showing that as a group, Hispanics are economically disadvantaged compared to non-Hispanics.[58] It is, therefore, appropriate to raise the question of whether the more general findings about treatment assignment of low-income clients are relevant to Hispanic clients. The relationship between social class and obtained therapeutic treatment is striking. Lower class clients are less likely to receive clinical services, and those who are treated receive services considered less prestigious. This pattern was described in the now classic work by Hollingshead and Redlich,[59] and upheld in the follow-up study by Myers and Bean.[60] Recent reviews by Lorion, Parloff, and Sue reveal that little has changed over the past four decades.[61]

In a much cited discussion, Schofield[62] described therapists' preference for the client who is YAVIS or young, attractive, verbal, intelligent, and successful, as opposed to the HOUND patient described by Goldstein and Simonson[63] as "homely, old, unattractive, nonverbal, and dumb." Adams and McDonald[64] described the ways in which poor people are discouraged from seeking psychotherapy and referred to less prestigious services. Clearly, the question of whether traditional therapies have been made available to lower class clients and/or are responsive to their needs is complex and problematical.

In his appraisal of the development of psychotherapy during the past 40 years, Garfield[65] pointed to the increasing number of therapies which are currently practiced. Teichner and Cadden[66] discuss the need to adapt traditional therapeutic frameworks when working with Puerto Rican clients. Green et al.[67] make the same point in regard to Mexican children. However, the view of these and other authors is that certain therapeutic modalities are either intrinsically in keeping with Hispanic values or readily lend themselves to adaptation. Family therapy has been identified as an appropriate treatment approach by a number of authors such as Szapocznik, Johnson et al., and Boulette.[68] LeVine and Padilla also discuss how psychodrama,[69] group therapy,[70] and assertiveness training[71] have been used in a culturally appropriate manner. On the other hand, elements of these therapies, such as confrontation, attack, and sex reversal role playing, are recognized as being unacceptable to many Hispanic clients.

Innovative modalities, that is, those designed with cultural considerations in mind, include Szapocznik's Life Enhancement Therapy,[72] a psychosocial approach designed to enhance the meaningfulness of life for Cuban elders, thereby alleviating depression. Another expressly Hispanic modality is Maldonado-Sierra and Trent's method of group therapy used with Puerto Rican schizophrenics.[73] A three-member therapy team representing significant members of a family provides treatment for a patient group, with attention given to relationships among patients, who play the role of siblings. Ruiz[74] makes the point, however, that not all Hispanic clients have the same need for treatment approaches that are geared toward this group. He proposes a continuum of acculturation from "completely Hispanic" to "completely Anglo." The more acculturated the client, the less the need for approaches specifically attuned to Hispanics.

Whatever the mode of treatment used, the question of whether appointments will be kept and treatment sustained is paramount. Sue et al.[75] found that Chicanos terminated counseling after only one contact at a rate of 50 percent, in sharp contrast to the 30 percent rate for Anglos. Miranda[76] reported that Mexican American women electing to remain in psychotherapy for a minimum of five sessions demonstrated higher levels of both psychological and behavioral acculturation than those women who terminated treatment prematurely. In their review of the types of factors which affect the likelihood of clients' dropping out of treatment, Baekeland and Lundwell[77] identify two factors which apply to Hispanics. Low socioeconomic status clients are more likely to drop out of treatment, a finding which may be applicable to Hispanic clients. Clients who are not able to see or label causal relationships between ideas and feelings pertaining to one's self and behavior are also more likely to drop out. This finding too is relevant to the large proportion of Hispanic clients whose concerns with economic survival preclude contemplation of the more rarified aspects of the human condition. Such a view is in keeping with Maslow's view of personality,[78] which acknowledges that physiological and safety needs must be met before the psychological needs for belonging and love, esteem and self-actualization can be realized.

Therapy dropouts are an elusive group for mental health professionals to study. Hence, Acosta's study[79] is a valuable contribution to this area of inquiry. Anglo, black, and Mexican American dropouts showed no significant differences in their reasons given for terminating therapy. Reasons provided were negative attitudes toward therapists and perception of therapy as not beneficial. This finding is in keeping with the discussion of Acosta, Evans et al.[80] who consider dropping out a result of unmet role expectations. Even when Hispanic clients are engaged in culturally appropriate, community-based treatment, external factors may work against involvement in long-term treatment. For instance, the duration of Aloyo's therapeutic work[81] with migrant workers depended not on the evolution of a therapeutic relationship but on the harvest cycle: when a seasonal crop was harvested, the clients moved on and therapy was terminated or suspended. In more traditional settings, one method of attempting to counter the high dropout rate is to provide new clients with an informational introduction to the nature of therapy through role induction.[82] In Acosta's introduction, appropriately titled "Telling It Like It Is," clients are shown a cassette program which prepares them for their role as a client. Other programs also prepare therapists for work with low-income clients.[83]

Engaging Hispanic clients in therapy is only a first step. Though the issue has been incompletely explored, some findings suggest that there are important process variables which must be taken into account when working with Hispanic clients. Sue[84] points out that Hispanics prefer an active therapist, perceive the therapist as an authority, and have been reared to show respect for authority figures by not speaking until spoken to. Acosta and Scheehan[85] found that Mexican American college students were less willing to provide self-disclosing information than their Anglo counterparts though both groups showed some willingness to self-disclose. Cross and Maldonado[86] indicate that Chicanos were reluctant to reveal personal matters to those outside the family.

Process research, concerned with events which transpire within the therapy session in the interaction between the therapist and the

client, is also worthy of attention.[87] Sue's review notes Hollingshead and Redlich's finding that lower class patients tend to have less intensive therapeutic relationships.[88] It should also be kept in mind that findings about the effect of process variables in the population at large may operate differently with Hispanic clients. For instance, the true importance of therapist characteristics -- genuineness, unconditional positive regard, and empathy -- which Rogers[89] proposed as necessary for constructive personality change to occur in the client has been widely debated.[90] Green[91] discusses the importance Mexican Americans place on positive interpersonal relationships. Whether genuineness, unconditional positive regard, and empathy are the interpersonal qualities likely to facilitate the therapeutic process with Hispanics is worthy of exploration, as is the more general question of whether process considerations, demonstrated in the population at large, generalize to Hispanics.

As with process considerations, the extent to which general therapy outcome findings are applicable to Hispanics is important. The question of whether or not therapy is more effective than no treatment has been a much debated issue[92] since Eysenck's controversial claim[93] that therapy clients fared no better than those on a waiting list. Over the past decades, his data have been reanalyzed and his claim countered. The consensus of the profession is that therapy is more effective than no treatment, as supported by "tally" type reviews of the literature[94] and more recently by Smith and Glass' meta-analysis[95] of psychotherapeutic outcome studies, in which data from 375 studies were combined, yielding the conclusion that the typical therapy client is better off than 75 percent of untreated controls. It is interesting to juxtapose Lorion's indication[96] that there is no difference by social class in the success of therapeutic outcome with Garfield's observation[97] that there has been a visible decline in the importance of psychoanalytically oriented therapies and long-term therapies in general. The concomitantly greater emphasis on therapies which are briefer and more active may be more likely to provide successful outcomes for lower class and Hispanic clients.

As Paul[98] pointed out, the general question of which psychotherapy is most effective can best be considered in terms of components. What treatment by whom is most effective for this individual with that problem and under which set of circumstances? Introduction of the ethnic group of the client, the therapist, and the surrounding cultural considerations adds a new dimension to these queries. Unfortunately, the studies which address therapy outcome in the Hispanic population are small and incomplete fragments of the entire picture. For instance, Boulette[99] compared the effectiveness of therapeutic listening and behavioral rehearsal on depressed Mexican American women and reported that neither approach was consistently effective. Acosta and Scheehan's finding[100] that Mexican Americans attributed more trustworthiness and skill to a Mexican American therapist when portrayed as a paraprofessional and to an Anglo when portrayed as a professional is noteworthy, given Frank's view[101] that the client's expectation of help from and faith in the therapist are elements common to all types of therapy. The Acosta and Scheehan study serves to underscore the notion that findings about the effect of therapist variables, such as race, perceived expertise, and interaction, uncovered from studies among mainstream Americans, may not generalize to Hispanics.

Though not conducted with Hispanic clients, Heffernon and Bruehl's study[102] is worth considering when addressing the issues of therapist variables, client preferences, and outcome. They found that although black children generally showed a stronger preference for black vs. white therapists, one particular white therapist with experience with this clinical population was also strongly favored. Although there are sometimes advantages in matching a client to a therapist of the same ethnic group, this match cannot be considered a panacea for the problems of minority group clients. Munoz[103] provides a poignant discussion of his own difficulties in treating Hispanic Americans, pointing out that minority group therapists who have recently emerged from poor communities may attribute their clients' problems to socioeconomic conditions even when the problem has a truly intrapsychic basis. Cummings[104] reported that when a group practice of therapists has an appropriate proportion of minority and female therapists, clients' demands for a certain type of therapist tend to disappear. Clearly, the issue is worthy of further consideration.

Barrett, Hampe and Miller[105] in their discussion of research on childhood psychotherapy lament the lack of resources directed toward disorders of childhood. Their review considers child psychotherapy research as no match in quantity or quality with the corresponding body of research on adults. The authors were particularly disconcerted by the lack of substantive attempts to grapple with the significant issues related to child psychotherapy. Ethnic minority youngsters tend to experience a disproportionately high incidence of mental disorder relative to their nonminority counterparts in urban settings, and furthermore, low socioeconomic status ethnic minority youngsters tend to underutilize traditional psychotherapeutic intervention facilities.[106] Moreover, youngsters in this population who attend traditional mental health clinics tend to drop out of psychotherapy early in treatment, thus failing to benefit from the intervention.[107]

The President's Commission on Mental Health[108] pointed out that a large percentage of American children grow into adulthood with mental disorders which might have been ameliorated through earlier psychotherapeutic intervention. Although an estimated 12 million youngsters under the age of 18 are currently affected by mental disorders, only about one million are in psychotherapeutic treatment. Thus, the 92 percent of these youngsters who remain psychologically untreated represent high risks for continued or more severe mental disorders when they reach adulthood.[109] Within this population, two million Hispanic and black youngsters, mostly from low socioeconomic backgrounds, are estimated to have severe mental health problems.[110]

One Hispanic Research Center study has demonstrated that school-age Puerto Rican children frequently experience serious personality disturbances and present higher risks for mental disorders than their white counterparts due to a vast array of economic, educational and, above all, psychological and bilingual factors.[111] Hispanic youngsters have been found to experience emotional disorientation, inferiority of feelings, and very poor self-esteem.[112] Furthermore, black youngsters experience similar problems, having been found to present more psychopathology than white youngsters.[113] Black youngsters, like bilingual Hispanic youngsters, also are reported to have inferiority feelings, low self-esteem, high trait anxiety, and low school achievement.[114]

Thus, there appears to be a compelling need to develop culturally sensitive modalities to remediate the psychological problems of ethnic minority youngsters in need of psychotherapy. Therefore, the HRC presents two research initiatives in this area. The first, a study of the effectiveness of the Unitas therapeutic program, and the second, an evaluation of folk-hero modeling therapy based on TEMAS protocols.

The Unitas program comprises primarily Hispanic and black youngsters in new York's deteriorated South Bronx area. Several hundred youngsters, ranging in age from 5 to 16, participate in the program during a given year. About half of the Unitas participants are referred to the program by parents or teachers as "problem children," usually evidencing severe symptoms of psychopathology such as withdrawal or bizarre behavior. The remainder of Unitas participants attend the program voluntarily, although they may not necessarily manifest maladaptive behaviors indicative of potential mental disorder.

Unitas is founded upon the concept of the

family unit as the most important natural institution that can satisfy a child's need for nurturance and discipline. Unitas, therefore, has created a system of symbolic families composed of up to 15 boys and girls, usually living on the same street, but not necessarily from the same biological family. Each symbolic family is headed by one or two older neighborhood teenagers who play the roles of symbolic mothers, fathers, aunts, and uncles. These teenagers receive intensive training in psychological therapy and clinical skills and become the primary caretakers and therapists of the younger children. Thus, Unitas' concept of therapeutic intervention is based upon the creation of a therapeutic community as a form of milieu therapy which stresses the importance of cultivating a positive and mutually helpful environment within the context of the treatment setting. In addition to the therapeutic community, an interpersonal model of psychotherapy is the primary approach used in Unitas to effect its goal of treatment of psychological and psychiatric disorders. This interpersonal model relies on an "extended family circle" as community therapy, as well as on play and family therapy. Unitas' highly active system of sanctions, which rewards valued behavior and the mastery of interpersonal skills while discouraging undesirable conduct, creates external pressure on the participants aimed at making the anxious and depressed youngster less fearful and withdrawn, the acting-out or aggressive youngster more socially acceptable, and the "bizarre" youngster more attuned to reality.

In the spring of 1981, the HRC published a two-year ethnographic study of Unitas, examining its organizational structure and interpersonal processes. The conclusions of this ethnographic study, published in the HRC monograph called *Unitas: Hispanic and Black Children in a Healing Community*, written by Dr. Anne Farber and Dr. Lloyd H. Rogler, raised the major question of the program's replicability. In order to replicate the program, a vehicle must be constructed to clearly transmit the program's methods. Therefore, as a companion to the monograph, the HRC undertook to develop a logistics manual which would attempt to present Unitas techniques in a sequential and integrative manner. The manual, now in press, is called *Unitas: A Training Manual for Building Healing Communities for Children*. Written by Dr. Edward P. Eismann, founder and director of Unitas, it will be published by the Hispanic Research Center as its eighth monograph. The manual has a twofold purpose: to describe the steps taken historically together with the methods and techniques used in the creation of Unitas as a healing community for children; and to offer a substantive example of a training curriculum that simulates the training given to Unitas teenagers and clinical staff.

Thus, the research initiative which the HRC proposes to undertake in the fourth phase is a logical extension of its past work with Unitas. Specifically, the objectives of the proposed research, entitled "Psychological Impact of Unitas, a Healing Community for Children," are: (1) to assess the therapeutic outcomes of Unitas relative to no therapeutic intervention; (2) to assess the therapeutic outcomes of Unitas relative to traditional group psychotherapy; (3) to assess selected interactions of type of therapeutic treatment (Unitas, traditional group therapy, no therapy) with DSM III psychodiagnostic classification (conduct, anxiety and depression, adjustment and personality disorders), ethnic group (Hispanic, black), age, and sex; (4) to assess long-term effects of the above therapeutic comparisons after a six-month follow-up period; and (5) to assess the replicability and cross-validity of findings in regard to the above objectives.

This research initiative focuses upon a comparison of Unitas therapy with a traditional group therapy and a no-therapy control condition in terms of several mental health outcome measures. The dimensions of mental health assessed as therapeutic outcome measures in this research represent adaptiveness of ego functioning: anxiety/depression, aggression, delay of gratification, achievement motivation, reality testing, moral judgment, self-esteem, and interpersonal relations.[115] Furthermore, these dimensions of mental health are defined by multiple measures[116] and will be operationalized at both intrapsychic and overt behavioral levels. Adaptiveness of ego functioning will be assessed dynamically and cognitively by TEMAS, a thematic apperception technique, and an anxiety self-rating scale. (How I Feel questionnaire, STAIC Form C-2), and behaviorally by clinical ratings in role-playing situations and teacher-parent ratings in classroom-home situations (Teacher-Parent Behavior Rating Scale).

The second research initiative the HRC proposes to undertake in this phase of the conceptual framework for epidemiological-clinical services research, entitled "Folk-Hero Modeling Therapy," is an evaluation of therapeutic outcomes of folk-hero modeling therapy with teenagers. This therapy modality provides symbolic modeling of adaptive ego functions by presenting stories of historical and folkloric figures of the Hispanic group studied.

Padilla, Ruiz and Alvarez[117] among others, have suggested, there exists an urgent need for innovative therapeutic modalities with Hispanics that bridge their conflicting Hispanic and American cultures. In this regard, recent attention has been given to the central role of "folktales" as a therapeutic modality, particularly as an effective means of ameliorating emotional problems and promoting personality and ego development in children.[118] Similarly, Gardner[119] has reported that mutual storytelling between therapist and child has resulted in positive therapeutic outcomes in both neurotic and borderline children. In one study involving black and Hispanic children, thematic fantasy play was shown to be associated with a higher incidence of spontaneous play, better story memory, and better story-telling skill.[120] Other investigators have found that storytelling has a positive effect on self-image and empathy in therapeutic contexts.[121] Nevertheless, there is a paucity of experimental literature on the effectiveness of folktale therapy on mental health, although the technique appears to have considerable promise for adaptation to Hispanic cultural experiences.

Folktales represent one of the most important elements of the folklore of a given culture. Throughout history, folktales have constituted the mainstreams of oral literature which has transmitted the culture across generations, and thereby fostered children's ego development. Folktales provide symbolic modeling of adaptive ego functions and possess therapeutic value because they embody both the affective (*mythos*) and the cognitive (*logos*) modes of experiencing. As a therapy modality, they have the capability of motivating the attentional process by presenting culturally familiar characters, by modeling characters, beliefs, ideas, and behaviors with which children can identify.[122]

Consequently, the principal objective of the proposed study is to investigate the effectiveness of folk-hero modeling therapy tailored to historical features of the particular subcultural background (e.g., Puerto Rican, Cuban, Colombian). In a project now under way at the Hispanic Research Center, we are endeavoring to validate folktale therapy with Hispanic children 5 to 9 years old. The research initiative we are presenting here will expand the folktale therapy to folk-hero modeling therapy for teenagers and adolescents. The need for development of a new culturally sensitive modality for teenagers stems from the extensive experience of one investigator at the HRC with ethnic minority and non-minority children, which indicates that teenagers tend to perceive folktales as "baby stuff" and therefore they generally do not pay attention to folktale therapy.

The folk-hero modeling therapy will consist of a series of stories which have folk heroes taken from folklore and the popular history of the Hispanic groups undergoing treatment. A careful review of the folklore of the Puerto Rican, Cuban, and Colombian subjects participating in the study will be made in

conjunction with a Hispanic anthropologist in order to select the most prominent folk heroes. Subsequently, stories will be written in conjunction with an expert in children's literature and Hispanic folklore. The stories will depict the folk heroes in a sequence of adaptive behaviors.

Based on the social learning and modeling therapy of Bandura,[123] the folk-hero modeling therapy provides symbolic modeling of adaptive ego functions using familiar historical and folkloric heroes within the Hispanic culture. This culturally sensitive therapy modality has therapeutic values because it embodies both the affective and the cognitive functions of human experience. Thus, folk-hero modeling therapy, by presenting symbolic models will foster adaptive ego functions such as achievement and motivation, self-concept of competence, judgment and reality testing, and ego defenses against anxiety and depression.

Thus, both of the HRC research initiatives in this phase of the conceptual framework will attempt to assess two culturally sensitive and innovative therapeutic modalities -- one is a complex therapeutic institutional structure, Unitas, and the other is a folktale therapeutic modality -- both to be used with a hard-to-reach group of clients whose unmet needs have been well documented.

Phase 5: Post-Treatment Rehabilitation of Hispanics

Phase 5 refers to the post-treatment phase of the epidemiologic-clinical services research framework. After a client terminates therapy or a patient leaves a psychiatric hospital, a new set of questions about the effectiveness of treatment comes into focus, questions such as how well he or she will be able to perform major roles, solve problems, and whether or not the continued support of professionals, paraprofessionals, family members, and other persons are needed to sustain the clients as functioning members of the community. At a broader level, questions need to be raised as to the impact of social-structural and cultural factors upon the post-treatment experiences of the client. We shall see that recent historical trends add significance to such questions.

Even though annual admissions to state hospitals increased from 178,000 in 1955 to a peak of 390,000 in 1972 (then decreased to 375,000 in 1974), fully 64 percent of the cases admitted in 1972 were readmissions.[124] The year 1972 also marked the apex of patients released from institutions -- over 400,000 -- with preceding and subsequent years close in number. The combination of high rates of deinstitutionalization and of readmissions lends credence to Bessak and Gerson's assertion[125] that despite the promise of treatment and rehabilitation imbedded in the community mental health concept, deinstitutionalization has often meant real hardship and tragedy to the thousands of hospitalized patients released haphazardly "to a non-system of community aftercare." Many of these individuals, discharged after a long period of custodial care, lead a marginal existence in the community, surviving on welfare payments, perhaps receiving some medication or counseling. Unable to cope, they return to the hospital to be maintained on anti-psychotic medication. Goldstein's observation[126] that 85 percent of the patients discharged as a result of deinstitutionalization are located in the socioeconomically lower or working class adds poignancy to the problem. Even though a significant portion of the Hispanic population is economically disadvantaged, we know very little about how all of this affects the post-treatment experience of Hispanic clients.

The two measures most often used to assess the post-treatment level of functioning of clients -- in particular, discharged chronic schizophrenics -- are rehospitalization and employment. The assumption is that if the individual continues to need institutional support, the number of days hospitalized since discharge and the time which has elapsed before rehospitalization was necessary may reflect the person's ability to cope -- provided attention is given to the life situation the person confronts. Being able to maintain a job also is an indication of post-treatment adjustment to the community. The employed individual is less likely to be a financial burden to the family and to society, evidences a capacity for some level of functioning, and is investing effort in a socially desirable activity. Although there is an extensive literature about aftercare and rehabilitation, and although psychotherapy outcome studies often include follow-up measures, attention to the prevention of relapse in recovered Hispanic patients and to their capacity for securing and sustaining employment has largely been nonexistent.[127] At the same time, research has generally neglected the post-treatment experience of Hispanic clients. Our bibliographical efforts indicate that the fifth phase of the five-phase epidemiologic-clinical services research framework has received the least research attention among Hispanic populations. Our discussion, therefore, will restrict itself to the following aspects of aftercare: the role of socioeconomic factors, interpersonal relations, employment, and posthospital treatment.

Socioeconomic status, as we have seen in the discussion of Phase 4, plays an important role in clients' experience of the mental health system. Social class continues to be a major factor in what happens after treatment as well. Thus, Zigler and Phillips and their colleagues,[128] using case history data to predict aftercare outcome for discharged schizophrenic patients, found that a high occupational and educational status and a good employment history (and being married) before hospitalization are among the variables which predict good outcome upon discharge. In Myers and Bean's[129] follow-up study of Hollingshead and Redlich's investigation of social class and mental illness, the deleterious results of being both seriously disturbed and a member of a lower class are strikingly documented. Not only are lower class patients more likely to be readmitted to the hospital, but those patients who remain outside the hospital are more likely than non-lower class patients to experience serious employment difficulties, financial problems, and extreme social isolation. Myers and Bean's thesis is that the lower the social class, the more severely handicapping is the role of the mental patient. The relationship between social class and posthospital adjustment within the Hispanic community remains a matter for empirical determination.

There has been a modicum of attention given to the nature of interpersonal relationships of Hispanic schizophrenics in the community. Amin[130] found that the retention of cultural values by Puerto Rican schizophrenic ex-patients was an important determinant of favorable posthospital adjustment. Classification of patients as retaining or not retaining their cultural values was largely based on the extent of social contacts with family and relatives. Garrison's[131] exploration of the social support systems of schizophrenic and non-schizophrenic Puerto Rican migrant women in New York City pointed to the greater social withdrawal and isolation of the schizophrenic women in comparison to the non-schizophrenics. As the author points out, this finding is unremarkable since the very same characteristics were secondary diagnostic criteria for the schizophrenic group. The data from her study indicate that social withdrawal occurs first from a spouse, then from the family (other than parents), then from unrelated persons. She recommends that instead of looking to the family to find support for the chronic schizophrenic patient in relationships that have frequently not been supportive in the past, the clinician might be better advised to encourage voluntary supportive non-kinship relationships. This view is consistent with Leff's[132] position that for discharged patients, contact with families is often deleterious. Rogler and Hollingshead[133] found, however, that severely disturbed schizophrenics in Puerto Rico who had never been hospitalized were able to

maintain some viable relationships within their family system, but were less capable of dealing with people and systems outside the family. One might speculate that the discrepancy between the Garrison findings and those of Rogler and Hollingshead may be due to differences in the researchers' respective populations. Rogler and Hollingshead studied individuals who had never been hospitalized and had remained within their families; Garrison studied individuals who had been separated from their families at least during the period of hospitalization. Hospitalization, therefore, may attenuate family bonds. Given the particular importance of family ties within the Hispanic culture, the nature and extent of interpersonal involvement on posthospital adjustment are worthy of careful investigation.

Summers[134] found that recently discharged schizophenics suffered more from social and vocational dysfunction than from acute symptom distress. Their data indicate that schizophrenics tend to be neurotically symptomatic and socially dysfunctional but not highly psychotic. Lack of performance of social function was evident after the acute phase, and most of the patients were unemployed. Recently, the topic of the relationship between the ex-patient's ability to work and his post-treatment adjustment received attention from Wansbrough and Cooper[135] and from Anthony.[136] Wansbrough and Cooper consider employment a critical variable on several levels: employment is an indication that a person can function at least minimally; it is an aid to rehabilitation; and it is evidence of wellness. In the context of Hispanic social structure and cultural diversity, the meaning and significance of work in interpreting the posthospital experience of clients very likely depend upon the socioeconomic level and the cultural group's normative orientation toward work and other institutional structures. Among Hispanics such issues remain unexamined.

Anthony[137] outlined a variety of post-treatment therapies which have been used in an effort to improve posthospital performance. These include: drug maintenance, aftercare clinics, follow-up counseling, and transitional facilities. From his review, the only modality which emerged as showing a lower rehospitalization rate than no treatment was the aftercare clinic. He raised the point that this group may be self-selected -- attendance at a clinic may be an expression of a desire to stay healthy. He also had a favorable evaluation of transitional houses in that, at the very least, they allow the discharged hospital patient to enjoy more freedom and less stigma. From a societal point of view, this type of care is less expensive than maintaining patients in a total institution. This finding could have relevance for Hispanic patients who are among the ranks of those needing aftercare and of those for whom traditional treatment modalities have left much to be desired. An innovative, potentially useful approach to aftercare for low socioeconomic status ex-patients, by implication for some Hispanic groups, may be found in Goldstein's recent work.[138] His starting point is that most of the discharged patients are substantially deficient in important skills necessary for daily functioning. His approach is to teach skills and desirable behavior, because long-term institutionalization renders the patients ill-prepared and vulnerable in the face of community demands following hospital discharge. However, as Wallace *et al.*[139] caution in their review of the impact of social skills training upon schizophrenic patients, the positive changes do not occur for every patient. And when they do occur, they often do not generalize to new situations. Next to nothing is known about this issue in regard to Hispanic groups.

In sum, the level at which an individual who is no longer in treatment is able to function is the product of factors arrayed across all phases of the epidemiologic-clinical services research framework. The general neglect of mental health relevant research among Hispanics in all phases of the framework, therefore, makes our ignorance all the more problematical. Specifically, there is a pressing need to focus research upon the fifth phase of the framework to identify factors which enhance or suppress the Hispanics' capacity to function.

The research intiative we propose in Phase 5 focuses upon lower socioeconomic status Hispanic psychiatric patients about whom we know very little. Although not directed toward Hispanics, research has demonstrated that higher socioeconomic patients who show greater adaptive social and vocational adjustment before hospitalization are most likely to return to the community and conduct a normal social life. In contrast, the majority of the lower socioeconomic status patients languish in delapidated hotels, rooming houses, halfway houses, and eventually become part of the revolving-door syndrome; that is, they return to be hospitalized over and over again. Although the problems of community adjustment of these patients are great, little research exists on the factors which enhance or suppress their capacity to function.

An important factor affecting the lack of success in treating low socioeconomic psychiatric patients is that the existing psychiatric classification treats personality as a monolithic structure rather than as comprised of semi-autonomous ego functions. The value of using the ego functions approach in understanding psychiatric illness rests on the fact that unlike the diagnostic evaluations of the DSM III, ego functions are theoretical constructs which are associated with observed behavior and patients' self-reports. Ego psychology deemphasizes the role of the psychoanalytic concepts of instinctual drives and emphasizes the role of reality relationships and psychosocial factors in the development of the ego.[140] By operationalizing personality as a series of semi-autonomous functions, the ego function approach affords less global and more specific diagnostic evaluations and a balanced assessment of pathological as well as non-pathological ego functions. Moreover, research has shown definite evidence that the traditional psychiatric diagnosis is not relevant to the goals of psychiatric rehabilitation.[141] In addition to its questionable validity and reliability, "it can be said with considerable research support, that the psychiatric classification system is unable to provide information about the helpee's rehabilitation potential." Conversely, instruments measuring ego strength, motivation, and self-concept are showing great promise in predicting posthospital vocational adjustment.[142]

By recognizing the complexity of semi-autonomous personality functions, treatment plans can be tailored to the specific needs of each individual to foster those specific skills such as communication skills, personal interaction skills, self-maintenance skills, and vocational skills in which the patient is deficient and which taken together are of paramount importance for adaptive community living. Thus, this initiative builds upon Goldstein's recent innovative work with lower socioeconomic ex-patients which explicitly recognizes that discharged patients are substantially deficient in important skills necessary for daily functioning. Our extension of this work involves differentiating this post-treatment therapy into specific skills for various ego functions in order to purposefully match appropriate skill-training therapies with the appropriate ego function needs of the patients.

Our research initiative in Phase 5, entitled "Structured Learning Therapy and the Community Adjustment of Hispanic Psychiatric Patients," will investigate the posthospitalization social and vocational adjustment of adult Hispanic schizophrenics undergoing a traditional half-way house program versus a program of social and vocational skill training for community living[143] adapted to the urban Hispanic experience. Preliminary research on this initiative overlaps with Phases 3 and 4 of the conceptual framework, inasmuch as pilot studies are necessary to standardize the assessment techniques on relevant Hispanic subgroups (Puerto Ricans, Dominicans, Cubans, and Colombians), and to develop

corresponding versions of the social/vocational skill training program tailored to the particular psychosocial problems common within these Hispanic communities. The psychometric component of this pilot research will focus on *(1)* standardization of vocational adjustment instruments (e.g., San Francisco Vocational Competency Scale)[144] with Hispanic schizophrenics, as well as a comparison group of white schizophrenics, and *(2)* adaptation of Bellack's[145] Ego Function Assessment Scales to Hispanic schizophrenics to explore the clinical utility of an alternate (to DSM III) psychiatric diagnostic classification in structuring the community skill training program.

Insofar as clinical psychologists perceive diagnostic profiles as crucial in bringing about an effective therapeutic intervention, an additional consideration of the proposed research is to vary the information community adjustment therapists have to work with in conducting the program of skill training. Thus, two experimental programs will involve community skill training adapted to Hispanics: one in which the therapist is provided with the patient's ego function profile, and one in which this information is withheld from the therapist. The effectiveness of these innovative community adjustment programs, then, will be contrasted with a traditional halfway house program by assessing pre-postintervention vocational adjustment scores in experimentally simulated work settings. Effectiveness of community adjustment training programs versus traditional post-hospitalization maintenance will be addressed as a function of Hispanic subgroup (with whites serving as a comparison group), age, sex, and demographic background (e.g., years of hospitalization, age of onset of disorder). All patients will be post-tested again for a six-month follow-up assessment to determine their personality functioning, the stability of social/vocational adjustment. In addition, pre-postintervention employment status will be evaluated, as will postintervention recidivism over a six-month follow-up period.

Summary

The need for a comprehensive framework integrating mental health relevant research on Hispanic populations is recognized in the *Report to the President's Commission on Mental Health.*[146] The report notes that the research literature on Hispanic mental health has yet to attain the status of an integrated body of knowledge into which programmatic research could be incorporated. In an effort to remedy the above-noted deficiency, the Hispanic Research Center has developed a framework which integrates specific research projects into a broader conceptual structure. These research projects represent different stages of the work the Hispanic Research Center proposes to do depending upon the availability of funding.

In broad terms, we conceptualize clinical services research as spanning a hypothetical temporal sequence. From beginning to end, the sequence can be divided into five phases: (1) psychiatric epidemiology, (2) utilization of mental health facilities, (3) psychiatric evaluation or diagnosis, (4) therapeutic procedures, and (5) post-treatment rehabilitation. Although this framework is not uniquely linked to a specific ethnic group, the literature emphatically makes the following points: psychiatric epidemiology studies to determine the mental health of Hispanics are scarce; Hispanics underutilize mental health services in relation to their mental health needs; Hispanics are prone to be misdiagnosed for a variety of reasons; the treatment they receive does not fit their culture and life circumstances; and, finally, they experience difficulty in resuming their customary social roles after undergoing treatment. Phases 2 through 5 comprise successive barriers which keep Hispanics from receiving the mental health care they need, while Phase 1 documents the need for such services. In the future we shall be developing further ideas within the context of this conceptual framework.

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